THE SMITH FAMILY CASE STUDY

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To my loving wife, my companion for life; to my living legacy, my children.
Thank you.

"An individual has not started living until he can rise above the narrow confines of his individualistic concerns to the broader concerns of all humanity."

Martin Luther King Jr.

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ABSTRACT

This thesis project is a family intake encountered in pastoral counseling, beginning with first with an individual counseling case, which gradually moves into family therapy. In particular, the thesis will follow the Smith family through childhood sexual abuse, infidelity, anger, communication problems – which have contributed to significant distress in their marriages. This thesis project will illustrate that marriage counseling can help resolve conflicts and heal wounds. Furthermore, this thesis project illustrates the importance of cultural sensitivity, the use of clinical assessments, treatment planning, and integrating an eclectic approach within a biblical framework of family counseling.

CHAPTER 1

THEORETICAL ORIENTATION

TO MARRIAGE & FAMILY COUNSELING

Introduction

Therapy is a powerful modality for interpersonal change. Therefore it is important for the therapist to have a clear theoretical orientation when approaching clinical work with individuals and families. As such, there are myriads of theoretical theories or specialized training that a therapist can espouse. Some therapists have a particular preference as it relates to a particular theoretical orientation; others prefer an eclectic approach, which is the approach that best describes my position.

When engaging in therapy, it is my practice to employ fundamental principles of a few key theoretical orientations, in particular: systems theory, structural therapy, cognitive behavioral therapy, and solution-focused therapy. The following is a brief overview of those modalities, including reference to scholarly research, and how these theories can be integrated successfully in counseling.

Systems Theory

The family's influence on its individual members cannot be underestimated. Most children develop their values, beliefs about self and others, and typical patterns of behavior within their family system (Adler, 1931). Alfred Adler, a pioneer in the use of a systems approach to working with clients, believed that individuals could be understood only within a social context and that the family provided the first and

most important context (LaFountain & Mustaine, 1998). Other writers support Adler's recognition of the family system's influence on individual family members. For example, Brown and Prout (1983) stated that the family is "the center of learning for social behaviors" (p. 83), and Lewis (1996) asserted that "it is seldom that a school counselor can successfully intervene in the life of a student without considering the continuous influence of the family as the primary social system for the student" (p. 93). Kraus (1998) also proposed that therapists "embrace the idea of children's problems being viewed in the social context of their families and a family being understood as a system" (p. 14). As suggested by these authors, a therapist can better understand an individual by maintaining a family systems perspective. The following concepts can be explored during consultation sessions with a family using systems theory.

Life Cycle Transitions and Extrafamilial Influences

Life cycle transitions refer to the developmental events that occur in all families (Walsh, 1993). Births, deaths, developmental changes in children as they age, and illnesses are examples of developmental events. It is beneficial for a therapist to assess any major life cycle changes that might have led parents to seek assistance. For example, the birth of a new child creates necessary changes in the existing family, and consultation may be sought to ease the transitional stress. Parents can be taught how to respond to their older child's new and perhaps excessive requests for attention; and the child can be taught to seek attention in appropriate

ways such as asking parents for some one-on-one time rather than misbehaving to get negative attention.

Separation and divorce are considered transitional events (Ahrons, 1999). Therapists are well aware of the effect that these experiences have on families (Amato & Keith, 1991). Therapists can provide parents with information about the effects of divorce on children as well as information regarding custody issues (Mullis & Otwell, 1998). Counselors and parents can also discuss ways to structure healthy communication between all family members to ease the transition from the familiar to the unknown.

Extrafamilial influences are events that are initiated outside the family such as moves or job changes (Goldenberg & Goldenberg, 2000), or societal/community changes (Ursano & Fullerton, 1990). Depending on the event, the stress from these changes can create immense stress for family members (Goldenberg & Goldenberg, 2000). Therapists are familiar with the impact these events have on children (Edwards, 2000) and frequently consult with parents about effective ways to ease these stresses. However, therapists also must be aware that adults can be affected negatively as well and should help them to seek assistance.

Boundaries

"Boundaries" is considered an abstract term, particularly when used to delineate the subsystems of the family (Minuchin, 1974). Boundaries are the rules that determine who participates in a subsystem and how they participate. Healthy families have clear boundaries. Clear boundaries not only allow family members to

be different from each other and to develop autonomy, but also allow contact, nurturing, and support among family members. When boundaries are not clear, families gravitate toward either enmeshment or disengagement (Minuchin, 1974). Enmeshment and disengagement indicate preferred styles of interaction and do not necessarily suggest dysfunction.

When boundaries are diffuse, enmeshment tends to occur (Minuchin, 1974). In families with very young children, enmeshment frequently develops between the parents (particularly the mother) and the children. Because infants and very young children need much care and nurturing, this interaction style is useful, but it becomes less functional as children grow older. When enmeshment is excessive or continues beyond the infant and toddler years, children may not be allowed to develop independence or assume responsibility for their actions. Problems in one person echo throughout the family system and strongly affect other family members, who may become over involved in the problem. For example, siblings often argue with each other. In enmeshed families, parents become involved in the argument, try to determine which child is right, and resolve the problem, rather than allowing siblings to solve the problem independently.

Children alter the family's structure and require flexibility in parenting styles to meet their developmental needs. Infants need nurturing and support, older children require guidance and structure, and adolescents need to develop independence and responsibility (Nichols & Schwartz, 1998). A functional family system allows independence while offering nurturing and support (Minuchin, 1974). Therapists can teach families about children's developmental needs and how parents can help them

meet these needs through allowing appropriate independence or providing needed support.

Parental Hierarchy and Power

In many family systems, power and control issues are prominent. Parental hierarchy and power pertain to the parents' leadership role in the family (Minuchin, 1974). According to Minuchin, families must have a strong parental subsystem with clear boundaries in order to function effectively. Exploration of the influence of extended family members will assist in determining who the decision maker in the family is. In single-parent families, the single parent and a grandparent or other relative may share leadership responsibilities. If the adults work together effectively, shared leadership can be useful; however, problems often arise when adults disagree on rules for the family.

A frequent occurrence in families with many children, in single-parent families, and in families where both parents work outside the home is that a child is given a leadership role (Anderson, 1999). If clear limits are set on the child's authority, this child can benefit the family by taking care of younger children and managing household chores. However, problems can develop if the child becomes parentified (Minuchin, 1974). A parentified child is given too much authority and is allowed to violate boundaries and intrude in decisions that should be made by the parents. Also, if the child is burdened with too much responsibility, childhood needs may not be met. Therapists can help parents decide on reasonable responsibilities, while still allowing children to be children.

Triangles

A well-known feature of systems theory is triangles. Bowen (1978), Minuchin (1974), and other family systems theorists (e.g., Goldenberg & Goldenberg, 2000) have discussed the concept of triangulation. Bowen observed that a two-person system is inherently unstable and that when anxiety becomes high within the dyad, a third person is "triangled in" to reduce anxiety. Often, one child in the family is consistently used as the third leg of the triangle. This child might be selected because of his or her position in the family constellation, looks, behavior, or other characteristics. As a result, the triangulated child may often exhibits behavioral or academic problems at school (Minuchin, 1974).

Minuchin (1974) suggested that triangles develop when there is conflict between the marital partners. For example, a partner may demand that a child take his or her side. Siding with one adult automatically means that the other adult is being attacked, which puts the child in a lose-lose situation. Families who consistently use one child to reduce conflict or stress between the partners often contend with behavioral problems. Therapists can offer suggestions for working with the problem behavior. However, if consultation indicates that parental conflict is very high, marriage counseling might be the treatment of choice.

Family-Directed Structural Therapy

Family-directed structural therapy (FDST) is an approach to family therapy built upon traditional concepts of structural family therapy (Minuchin, 1974; Nichols & Schwartz, 1995), the strengths model (Rapp, 1998; Saleebey, 1996), and group

work theory (Anderson, 1997). The FDST approach has been defined as a goal-oriented, time-limited approach that enables the family to identify strengths and areas of concern, as well as to enhance family functioning.

The FDST approach is time-limited, and family progress is easily measured; thus this approach to helping families is particularly useful. FDST structured modality moves beyond the pathological and constrictive conceptualization of a diagnosis; instead, FDST is a goal-oriented process that empowers the family through identification of strengths and the provision of concrete skills and is designed to be utilized by the family both inside and outside the clinical setting.

Practitioners of FDST suggest ideas and techniques to aid the families in discussing role identification, boundary clarification, and addressing external stressors and areas of concern. These suggested ideas generally consists of the following components (Rapp, 1998; Saleebey, 1996):

1. Identify individual and family strengths and build on them. Inherent in this idea is the belief that all families have resiliency, self-awareness, and the ability to produce positive change.

2. All family members have the right to express what they think, how they feel, and what they need. All other family members involved have the responsibility to decide what needs can be met or all persons involved have the responsibility to decide how the conflict will be resolved utilizing the family's rules of engagement.

3. "I/me" messages are utilized, not "you/we" messages. This encourages each family member to take personal responsibility for their feelings and actions.
In healthy families, more needs are met than not met. In no family are ALL needs met at all times.

4. Each family determines "rules of engagement." These may include a contract not to engage in physical violence, not to become verbally abusive, or any other parameters upon which the family agrees. It is important to note these "rules" can be different for every family.

5. Avoid use of the word "but." Positive language is encouraged over excuse making.

6. Perfect behavior and trouble free relationships are not the goal. When family members can make positive and healthy decisions 60% of the time, this is an indication of roles and relationships moving toward a healthier and more stable state.

7. Family members are encouraged to learn to "agree to disagree" as a means of resolving conflict. This technique is based on the core issues of commitment (the willingness to see situations through, despite differences and conflict) and empowerment (having a sense that one's opinion is valued and respected).

8. "Agreeing to disagree" teaches family members that they can disagree and still value and respect one another's opinion. By "agreeing to disagree" via: (a) utilizing "I and me" messages (thus taking responsibility for personal feelings and actions); (b) stating what one thinks, feels, and needs, and; (c) understanding that all individual needs will not be met, a healthy way to resolve conflict is facilitated.

9. The addressing of conflict, whether from an external stressor or source inside the family structure, needs to be addressed via the appropriate relationship role.

10. Family members are encouraged to consider the idea of "reasonable expectations" when interacting with other family members.

As with any therapeutic approach, there are limitations to the utilization of FDST. Authors (Rapp, 1998; Saleebey, 1996) observe that use of FDST is not helpful in families where there is active domestic violence or threat of harm to self. In these cases, regardless of the theoretical modality employed, some form of crisis intervention is recommended to stabilize immediate risk, and some level of stability should be demonstrated prior to considering treatment.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is a form of psychotherapy that emphasizes the importance of cognitions as they relate to emotional health. Cognitive-behavioral therapy is based on a theory which attempts to explain personality and human behavior by understanding cognitive processes. Therapists in this tradition work under the premise that specific cognitive contents and their grouping in some way characterize psychiatric disorders; hence, the goal of cognitive-behavioral therapy is to identify cognitive distortions and modify the patient's thinking. Cognitive-behavioral therapists believe it is the tendency of individuals to respond to life experiences based on constructed schemas. These schemas are cognitive structures of codified learned behavior which are shaped by personal values, core beliefs, thoughts, feelings, and other motivations. It is generally believed that these schemas develop early in life, are the result of internal and environmental factors, and are unique to each individual. Schemas are defined as mental structures that help organize and interpret past and present experiences. Schemas are complex patterns of thoughts that determine how experiences are perceived and conceptualized and are unfortunately employed in the absence of verifiable data; therefore, schemas tend to reinforce preconceived ideas and cause them to be deeply imbedded. Hence, psychological problems are viewed as stemming from faulty learning, incorrect inferences based on inadequate or incorrect information, and the lack of adequate distinction between distorted imagination and reality (Freeman & Dattilio, 1992; Freeman, Simon, Beutler & Arkowitz, 1989).

In short, these mental structures create their own emotional and behavioral difficulties. Thus, cognitive-behavioral therapy asserts that how people feel and behave is largely determined by their cognitions and aims to change how people structure their thought processes as they relates to their emotions, thinking, and behavior (Freeman & Dattilio, 1992).

Historical Origins of Cognitive-Behavioral Therapy

There are several related approaches to cognitive-behavioral therapy, including rational emotive behavior therapy, rational behavior therapy, and behavior modification. It is generally understood that rational emotive therapy developed by Albert Ellis in the mid-1950s, was a precursor to cognitive-behavioral therapy. Reportedly, Ellis developed his approach in reaction to his dislike of traditional psychoanalysis. In the 1960s, Dr. Aaron T. Beck, who was also trained in psychoanalysis, developed the system of psychotherapy called cognitive therapy. The Beck Institute for Cognitive Therapy and Research was founded in 1994 as a natural outgrowth of Beck's original Center for Cognitive Therapy at the University of Pennsylvania (The Beck Institute, 2000). In the 1960s, Maxie C. Maultsby, Jr., M.D**.**, a student of Ellis, developed rational behavior therapy. Maultsby's contributions to the development of cognitive therapy were numerous; these developments included the introduction of an emphasis on client rational self-counseling skills and the utilizing of therapeutic homework for the client. Other notable theorists and practitioners include Michael Mahoney, Donald Meichenbaum, David Burns, M.D.**,**

and more recently, Catherine Padesky, Marsha Linehan, and Arthur Freeman (National Association of Behavior-Cognitive Therapy, 2004).

Research on behavioral and cognitive psychotherapies has been carried out extensively and has shown it to be an effective form of psychotherapy, particularly for depression, panic disorder, anxiety, anger, marital conflict, loneliness, eating disorders, substance abuse, personality problems, obsessive-compulsive disorder, and paranoia (Corsini & Wedding, 2000).

Cognitive-Behavioral Therapy as a Model of Psychotherapy

Cognitive therapy uses a learning model of psychotherapy and is based on a collaborative relationship between the therapist and the patient. The therapist and the patient examine the patient's belief systems through training techniques designed to specifically target distorted conclusions and their underlying hypotheses. Thus, understanding the participation of the therapist and patient in this model is critical. The patient acts as an active co-investigator of his or her own thought processes, while working in tandem, the therapist provides skills and insights for guided discovery. Thus, cognitive therapy is commonly described as "collaborative empiricism" (Corsini & Wedding, p. 242). The therapist helps the patient recognize cognitions and test the validity of thoughts, beliefs, and assumptions and encourages the client to make desired changes in thinking and behavior. This process is guided as opposed to confrontational, thus facilitating a therapeutic environment that will maximize the client's involvement and minimize the client feeling the therapist is

intrusive or imposing. In addition, this approach encourages the collaboration on therapeutic goals and outcomes.

Cognitive-behavior therapy differs from psychoanalysis in that it does not seek to uncover unconscious contributing factors leading to dysfunction, but rather it strives to help the patient find new ways of processing thoughts and feelings. In many respects, in the cognitive-behavioral model, the therapist is a pragmatic diagnostician, in so much that in this model the therapist spends considerable time gathering and integrating information provided by the client in hopes of educating and assisting the client in acquiring cognitive skills for behavior control.

Cognitive Behavioral Therapy: A Model of Health & Abnormality

Generally speaking, the cognitive-behavioral model teaches that when our cognitions are healthy (normal), it is our thinking (cognitions) that causes us to feel and act the way we do. Therefore, if we are experiencing unwanted feelings and/or behaviors, a cognitive-behavioral therapist focuses on identifying the thinking that causes the feelings/behaviors and teaching the client how to replace his or her thinking with thoughts that lead to more desirable reactions. Speaking on this, Jones and Butman (1991) put it this way, "In Beck's mind, the distorted thinking is not the symptom of the problem; it is the cause of the problem" (Jones & Butman, pp. 204-5).

Since models of mental health and abnormality in this model are identified through examining cognitive structure, psychological health is evaluated by interpersonal effectiveness, or the ability to adjust, respond, adapt or regulate

emotions or behavior appropriately. Abnormality would include irrational or distorted cognitions, such as, arbitrary inferences, conclusions made without substantiated evidence, selective abstraction, and inappropriate exaggeration or minimization and excessive personalization of events and thoughts.

Cognitive therapy sees distorted thinking or irrational beliefs as the basic structures that predispose us to psychological distress, but not necessarily as the cause. In cognitive therapy the cause of psychological distress can be initiated by a number of factors, which include innate dispositions that make up our individual personalities; and a host of environmental and biological factors are not ruled out as causes either. (Corsini & Wedding, p. 248) Because there is no single cause of psychopathology, models of health and abnormality are identified by the client's present cognitive structuring. Psychological health is determined by interpersonal and vocational effectiveness, as it relates to the client's emotion, and behavior as being desirable or undesirable. In general, because the cognitive-behavioral model focuses on cognitions and behavior, Butman and Jones (1991) note that this model is "sketchy about defining normalcy and abnormality" (Jones & Butman, p. 206).

Cognitive-Behavioral Therapeutic Techniques

Cognitive therapy initially focuses on symptom relief, but ultimately the goal is to identify the client's underlying distorted assumptions and then offer new ways of thinking or behavior as desired. The patient's beliefs are treated as hypotheses to be tested; they are logically examined and tested by both therapist and patient. In behavioral and cognitive psychotherapies the therapist and the client work together to

(1) develop a shared understanding of the client's problem and (2) identify how these affect the client's thoughts, behaviors, feelings and daily functioning. The focus of therapy is to enable the clients to generate solutions to their problems that are more helpful than their present ways of coping. Therapy is organized over an agreed number of sessions; the number of sessions needed varies depending on the nature and severity of a client's problem. Typically, therapy time and the number of sessions are considerably less compared to other models of psychotherapy. Generally, sessions are weekly, lasting about an hour. In most cases, it is recommended after treatment completion, the client and therapist usually agree to a limited number of follow-up sessions to maintain the progress achieved (Grazebrook & Garland, 2005).

Cognitive treatment employs many strategies, including Socratic questioning, idiosyncratic meaning, labeling of distortions, questioning the evidence, and examining options and alternatives. Other techniques to help encourage cognitive changes include replacement imagery, cognitive rehearsal, behavioral techniques, and homework (Freeman & Dattilio, 1992).

Concerning the success of cognitive-behavior therapy, numerous outcome studies show that cognitive therapy is as effective or more effective than medication in the treatment of moderate forms of depression, anxiety, and obsessions, without the negative side effects of medications (Corsini & Wedding, p. 246).

Solution-Focused Counseling

Solution-focused strategies were designed by family counselors (De Jong & Berg, 1998; Nichols & Schwartz, 1998) to provide a model of brief therapy that

focused on small changes and on solutions (what is going right) rather than on problems (what is going wrong) (Goldenberg & Goldenberg, 2000). Instead of striving for drastic changes in a family, O'Hanlon (1999) suggested that very small changes help people see a difference in their lives. It is theorized, by doing something – anything – different, behavior change can occur.

Most types of psychotherapy involve exploring feelings, being validated, finding explanations, exploring wishes and dreams, setting goals, and gaining clarity. In contrast, instead of going over past events and focusing on problems, the therapist helps to envision the future without today's problems. Solution-focused counselors aim to provide clients with the most effective treatment in the most efficient way possible so that clients can achieve their goals and get on with their lives. As a result of this focus, the counseling process often requires as few as six sessions. The therapist's role is to help the clients identify solutions that will remove their barriers to having the life they desire. As such, this type of therapy tends to be shorter-term than traditional psychotherapy.

The two key therapeutic issues are (1) how the client wants his or her life to be different, and (2) what it will take to make that happen. The creation of a detailed picture of what it will be like when life is better is a key feature of solution-focused counseling. This problem-free picture creates a feeling of hope for the client and makes the solution seem possible. Without a clear picture, therapeutic goals will be ambiguous and counseling less effective. Focus on the future and how it will be better when things change keeps therapy going in the right direction. Therefore, it is

important to develop a set of specific, detailed goals at the outset. These goals are the driving force of the therapy process and keep it focused and efficient (Coan, 1999).

Solution-focused questioning is viewed as a consultation tool that can be used to discover what is going right with families and individuals. Berg and Miller (1992) describe five types of questions that are based on the belief that the best way to help clients is to build on their strengths and resources.

The first type of questioning is aimed at eliciting descriptions of change that occurred before the client sought the assistance of a counselor. This is based on the thinking that clients often begin changing their problem behavior prior to seeking help (Berg & Miller, 1992). This vein of questioning helps clients see that not only is change possible, but also it might have already begun.

The second type of questioning is geared towards finding exceptions. This type of questioning helps clients to consider times and situations when the problem does not occur. De Jong and Berg (1998) suggested that if the clients have difficulty thinking of exceptions, the counselor could ask them to answer as if someone else would answer. This type of questioning helps clients see that they do possess successful strategies for changing behavior.

The third type of questioning helps clients define their goals and also prompts them to notice small changes. It is important that clients have clarity as to how they will recognize when improvement has been made. It is not uncommon that clients will not immediately recognize when incremental changes occur. When they do struggle with stating their counseling goals in specific terms, a clarifying question (Berg & Miller, 1992) is especially helpful. An example would be:

> "Suppose that one night, while you were asleep, there is a miracle and the problem that brought you into therapy is solved. However, because you are asleep you don't know the miracle has happened. When you wake up in the morning, what will be different that will tell you that this miracle has taken place? What else?" (Berg & Miller, 1992, p. 13)

It is hoped that this type of questioning will help clients to specifically describe their counseling goals, visualize the behavior sought, and notice goal attainment.

The fourth type is commonly called scaling questions. "On a scale from one to ten, with one being failure and ten being complete success, how would you rate how you're doing with your problem right now?" Scaling questions are considered quick assessments that yield valuable information that assist the counselor and the client as to know where they are and where they would like to be. According to Berg and Miller (1992), scaling questions are also useful because they help clients focus on small changes that can then be encouraged or reinforced. Often when clients seek assistance from a counselor, they have a list of things they would like to change in their family. Scaling helps to prioritize the most pressing problem, so that the appropriate amount of time is geared toward meeting those goals.

The fifth type of questioning is used to highlight the coping strategies that parents employ when faced with their problem. Poor coping skills are prominent issues in cases where family problems have been allowed to fester. Asking, "How do you manage to keep going?" can point out some instance of success and is especially useful when working with parents who feel discouraged (Berg & Miller, 1992). These types of questions are designed to expose existing strategies, both undeveloped and developed, that demonstrate to the client that they have the power to solve their

problems or to cope with them successfully. Counseling and theraputetic outcomes become easier to attain when clients begin to realize that they already have successful strategies. This allows the counselor to act as a coach, encouraging the client to continue using the recognized strategies.

Encouragement

A key component of solution-focused therapy is encouragement. Encouragement is essential for both individuals and the family as a whole. For example, in parenting cases, encouragement, which focuses on the parents' resources, empowers them (Eckstein, Belongia & Elliott-Applegate, 2000) and is elemental in promoting change (Dinkmeyer et al., 1987). It is the "process of instilling confidence to do something different" (Dinkmeyer & Dinkmeyer, 1983, p. 318). Therapists also use encouragement to help break down or prevent resistance. Particularly with family systems with parenting issues, practitioners of this model say, using encouragement techniques with parents yields positive results. Dreikurs and Soltz (1964) wrote extensively of encouragement being the most important and powerful aspect of raising children. They defined encouragement as a "continuous process aimed at giving the child a sense of self-respect and a sense of accomplishment" (Dreikurs & Soltz, 1964, p. 39).

It is important to note, encouragement is not reassurance (e.g., telling clients that everything will work out fine if they persist or that there is nothing to fear), nor is it praise. In therapeutic terms, encouragement focuses on the process of encouragement (Dinkmeyer, Carlson & Dinkmeyer, 1994), rather than simply saying,

"You did a great job. The difference between praise and encouragement can be subtle; however, it is helpful to remember that "praise puts the emphasis upon the product, while encouragement stresses the effort of contribution" (Dinkmeyer et al., 1994, p. 153).

It is not uncommon for counselors to be so focused on solving problems that they do not take the time to encourage their clients. It is helpful for counselors to remember that clients are often discouraged and extinction discouragement is encouragement, and every effort made towards utilizing encouragement will counteract the stated problem behavior.

Conclusion

What happens during the course of therapy is an interesting matrix of interdependent variables, some of which includes the therapist's views of how emotional and behavioral problems develop. Consumers of mental health services have the right to ask the therapist about his or her theoretical orientation. With the appropriate education, and with clear understanding of their theoretical orientation, a therapist can view and interpret the concerns expressed; and with the information provided by clients, the therapist then in turn can provide helpful insights to assist clients through difficult periods of their life. Regardless of orientation, the goal of therapy and the plan of interventions should be clearly stated and understood by both the clinician and the client. If both the practitioner and the client are comfortable with different clinical styles, both can proceed confidently. Therefore it is important for

clinicians to practice with congruence and for clients to choose a therapist whose style of working matches their unique needs.

CHAPTER 2

BIBLICAL FOUNDATIONS FOR MARRIAGE & FAMILY COUNSELING

Introduction

Since the 1950s, our culture has experienced decades of sociopolitical change. These changes include the Cold War era, the civil rights movement, and the sexual and drug revolutions of the 1960s. The Baby Boomer generation ushered in a period of swift change since which western civilization and the Christian church have been forced to define and redefine the meaning of "marriage" and "family." Sixty years later, in the new millennia, the Christian church and clergy and Christian counselors are being constantly challenged by the media and special-interest groups regarding our longstanding Christian view of marriage and family life. The Christian view and understanding of the institution of marriage and family relationships are informed by the Bible and years of theological research and biblical interpretation. However, we now live in a culture that no longer embraces these tenets or wishes to be guided by its principles – hence the ideology war about marriage and family. As with all wars, truth and fiction are often misunderstood due the propaganda that is published by the warring factions. As such, there have been debate, national polls, research studies, and a push for a constitutional amendment to end the confusion regarding the terms "marriage" and "family." With cohabitation and homosexual unions, we have competing sociopolitical schemas; one secular or humanistic, the other Judeo-Christian. Each view of the family is vying for legitimacy and supremacy; hence the need for a clear and informed biblical foundation for marriage and family counseling.

The Traditional Family

When considering parish ministry and clinical practice, having a clear biblical understanding and a concise theological perspective is crucial for personal and professional congruency. Andreas J. Köstenberger's contribution to a biblical understanding has been helpful.

Köstenberger, director of Ph.D. studies and professor of New Testament at Southeastern Baptist Theological Seminary, suggests that the current crises in the United States regarding the biblical foundation for marriage and family is symptomatic of a "deep-seated" (Köstenberger, 2007, p. 1) spiritual crisis, and that this upheaval is constantly attacking and eroding the Judeo-Christian view of marriage and family. If indeed the cultural crisis is symptomatic, then Köstenberger is correct, which will mean the solution to our current predicament is spiritual, not merely cultural or political. Nevertheless, cultural norms have an effect on the collective beliefs about marriage and family.

In a recent survey, LifeWay researchers solicited responses as to the top 10 issues facing today's family." More than 2,000 people from around the country were part of this project. The survey appeared in Family Today in 2006, the respondents reported the following (Biblical Foundations, 2002):

1. Anti-Christian culture
2. Divorce
3. Busyness
4. Absent father figure
5. Lack of discipline

6. Financial pressures

7. Lack of communication

8. Negative media influences

9. Balance of work and family

10. Materialism

The purpose of this chapter is not to definitively end the argument of whether or not blame for our current state of affairs should be placed on culture or America's supposed spiritual decline. However, the relationship between the two is undeniable, and the discussion is warranted. Statistics on the traditional family in America revealed in a recent Gallup Poll illustrate how the American family landscape has changed. "According to the 1999 National Survey of America's Families, one in three children (33%) live either in single-parent or blended families. According to 2001 U.S. Bureau of Labor Statistics data, in nearly two-thirds (63%) of two-parent families, both the mother and the father work. The days when a 'traditional' family consisted of two parents – a working father and a stay-at-home mother – are long gone, and the roles and expectations of American fathers have changed dramatically" (Gallup, 2002). Evangelical Christians are very concerned about the survival of the traditional family, in particular the plight of our children being reared in the wake of divorce. Christians believe the biblical message is the solution to spiritual edification of the marital dyad and the reshaping of culture for the rebuilding of the biblical family. The Bible is not silent regarding the important issues facing families today.

For centuries, the Scriptures have offered relevant and salient information for varying societal maladies. The holy Scriptures record the implementation of the marriage covenant and the institution of marriage. The Bible is also a reliable source for teaching on all family relationships, including parental and intergenerational. These relationships form the basic underpinnings of society. Biblical principles guide the therapeutic approach to therapy by providing a paradigm of normality and health. Since the marriage dyad is the smallest building block for community and society, marriage and family life are both the problem and solution, thus making marriage and family therapy a powerful leveraging tool for societal change.

Christian Anthropology

By definition, anthropology is the study of humanity. Therefore Christian anthropology would then be best understood as the study of humanity from a Christian/biblical perspective. Questions about the nature of humanity and how humanity relates to God form the foundations for Christian anthropology and the theological foundations for Christian counseling.

Evangelical views relating to marriage and family are often contrary to prevailing current conventional wisdom. For Christians, biblical and theological principles cannot be ignored either in parish ministry or in private practice. In my parish ministry and clinical interactions, theological and biblical views form the basic underpinnings of therapy and guide the therapeutic process form intake to discharge.

In preparing this chapter, the Nazarene Manual was referenced for congruence. As an ordained elder in the Church of the Nazarene, I am required to be

guided by the Nazarene Articles of Faith regarding issues connected with Christian anthropology and theology. The following questions and the positions offered as answers form my personal theological understanding of marriage and family and the processes necessary for positive change toward a biblical model for healthy and fulfilling relationships. Because an exhaustive list of questions cannot be offered here, only those questions considered relevant to marriage and family are considered.

Is humanity is made in the image and likeness of God (Genesis 1:26-27)?

If anthropology is the study of humanity, then for the Christian, Genesis is the place to start. From the Genesis account, we learn that there is a divine Creator and that humanity is a part of the created order, of which humanity occupies a special position (Gen 1:26-27). The image of God refers not only to humanity's positional uniqueness but also our relational connectedness to God.

It is recognized that the "likeness of God" is a difficult expression to understand precisely; thus, the wisdom and traditions of the church take precedence where my personal scholarship is insufficient. It is the Nazarene position that "likeness of God" refers to the immaterial part of humanity. It represents humanity's uniqueness, and it is this uniqueness which sets humanity apart from the animal world and qualifies humankind for the "dominion" God intended (Gen 1:28). Furthermore, being created in the likeness of God enables humanity to have a communal relationship with God. It is a likeness that is expressed mentally, morally, and socially. Nazarenes believe that the human race's creation in God-likeness also included the ability to choose between right and wrong, and that thus, human beings

were made morally responsible; that through the fall of Adam we became so depraved that our depravity inhibits us from turning to or calling upon God. But we also believe that the grace of God through Jesus Christ is freely bestowed upon all people, enabling all who will to turn from sin to righteousness, who believe on Jesus Christ for pardon and cleansing from sin, and who follow good works pleasing and acceptable in his sight (Church of Nazarene, 2008).

Herein lays the first key to change. Christian counselors should be able see their client as someone who has been created in the image of God, and the therapeutic interaction with the client should reflect congruence with this principle of humanity being created in the "image of God." Second, the counselor allows the client to see life from God's perspective – someone who has been created in his image. Though that image has been marred by sin, it has not been destroyed, and a positive response to God's gracious invitation to be conformed into the image of his Son is open to all. When we are in Christ and him in us, we are regenerated, renewed, and born again, and this new creation is spiritually minded. This is where Christian counseling differs from other forms of therapy. Christianity recognizes the valuable and unique qualities of the human soul. Where other forms of therapy consider spiritual beliefs as something to be cured, Christian therapy encourages the reconciliation of our spiritual hurts.

What is the Christian view of sin?

Sin is a spiritual condition, and its effects on human behavior, choices, emotions, and feelings are important to Christian therapists and must not be

underestimated. A generic explanation of the origin of sin is normally referenced through Genesis 3. Through Adam's choice to disobey God, the inherent inclination to sin entered the human race, and human beings became sinners by nature. Nazarenes believe that sin is of two kinds: original sin or depravity (Gen 3; 6:5; Job 15:14; Ps 51:5), and actual or personal sin (Matt 22:36-40, John 8:34-36).

Original sin, or depravity, is that corruption of the nature of all the offspring of Adam. When Adam sinned, his inner nature was transformed by his sin of rebellion, bringing to him spiritual death and depravity, which was passed on to all who came after him. Thus, humans became sinners not because they sinned; they sinned because they were sinners. This is the condition known as inherited sin or original sin. Nazarenes further believe that original sin continues to exist with the new life of believers, until the heart is fully cleansed by the baptism with the Holy Spirit. Original sin must not be confused with actual sin. Actual or personal sin is a voluntary violation of a known law of God by a morally responsible person.

Though sin is discussed throughout the Bible, the message of atonement culminates with the gospel message. As Nazarenes we believe that Jesus Christ, by his sufferings and the shedding of his own blood, and by his death on the cross, made a full atonement for all human sin (John 3:16). This atonement provided by Jesus is the only grounds for salvation of humanity. This message of hope builds on the change process discussed previously. As we recognize our sin, we are offered an opportunity for forgiveness and a new beginning. This part of the change process will be discussed a little later in this chapter.

What does the Christian message say about marriage?

The divine institution of marriage is introduced in Genesis. Like other evangelicals, Nazarenes believe the institution of marriage is ordained by God and is "honorable in all" (Heb 13:4) Nazarenes believe the institution of marriage consists of the voluntary union of a man and a woman for fellowship, mutual helpfulness, and the propagation of the human race. When a man and woman are married, the Bible calls their union a "one flesh" (Matt 19:5) relationship. The importance and permanency of this covenant is illustrated by the New Testament warning to anything that will threaten their sacred bond: "Wherefore they are no more twain, but one flesh. What, therefore, God hath joined together, let not man put asunder" (Matt 19:6). Several Epistles written by the apostle Paul speak to the issues that govern a biblical view of marriage and how marriage relationships should operate. We find one such passage in 1 Corinthians 7 and another in Ephesians 5:22-33. When studied together, these two passages provide a blueprint of biblical principles for successful marriage relationships.

The passage found in Ephesians is especially profound in its scope in reference to a successful biblical marriage. "Wives, submit yourselves unto your own husbands, as unto the Lord for the husband is the head of the wife, even as Christ is the head of the church: and he is the saviour of the body" (Eph 5:22-23). "Husbands, love your wives, even as Christ also loved the church, and gave himself for it" (Eph 5:25). "So ought men to love their wives as their own bodies. He that loveth his wife loveth himself. For no man ever yet hated his own flesh; but nourisheth and cherisheth it, even as the Lord the church" (Eph 5:28-29). "For this cause shall a man

leave his father and mother, and shall be joined unto his wife, and they two shall be one flesh" (Eph 5:31). When these principles are chosen by a husband and wife in harmony, we begin to see the beautiful portrait of a biblical marriage. This is not a lopsided relationship regarding power and control or positional importance, but one that is in balance with the concept of Christ as the head of the man and the wife together. Therefore, the biblical concept of marriage is an oneness between two individuals. That is a picture of the oneness relationship of Christ with his church.

What does Christian message say about equality between the sexes in marriage?

The Christian message regarding marital roles, particularly the role of the wife, has caused much debate and conflict. The source of the contention stem from the words "help" and "meet" (Gen 2:20) used to characterize the role of Eve. The role of Eve, and the subsequent expectations for the marital dyad, has caused significant misunderstanding and confusion between the genders. The Hebrew word that is at the source of such debate is *ezer cenegdo.* Joseph Coleson (1996), professor of Old Testament at Nazarene Theological Seminary, in "Ezer Cenegdo: A Power Like Him, Facing Him as Equal," notes, "English versions consistently translate 'ezer' as 'helper.' This is possible, but if we translate it this way, we must avoid the English connotation of someone of inferior status or skill" (p. 11). Coleson teaches the root for *ezer* means "strength" or "power" (p. 13). Therefore, an amplified yet theologically sound translation of *ezer cenegdo* can be translated "a power like him, facing him as equal," rather than simply as "helper." If Coleson's scholarship is correct, God's design for humanity included equality between the genders;

conversely, male dominance over females must be seen as a result of sin and the fall recorded in Genesis 3. Herein lays the second key to positive change – creating balance in our relationships. Power and control are two of the most significant issues in any relationship. The more trouble the relationship faces, the more power and control issues will come to the surface. The Christian message of mutual submission and respect help bring balance to marriage relationships. When relationships have fewer power and control issues, there are fewer incidents of abuse and violence. Power and control issues as they relate to abuse will be addressed a little later in this chapter.

What does the Bible say about divorce and remarriage?

Throughout the Protestant church there exist a variety of positions concerning the biblical view of divorce and remarriage. Despite the myriad of views, the Scriptures take the marriage covenant very seriously. Clearly the Bible permits divorce and remarriage in some situations, as there are examples in both Testaments. One of the strongest arguments for the permanency of the marriage covenant is recorded in Malachi 2:16a: "I hate divorce, says the Lord God of Israel." It is the general conviction of Nazarenes that God's plan is that marriage should be a lifetime commitment. "So they are no longer two, but one. Therefore what God has joined together, let man not separate" (Matt 19:6). God realizes, through ignorance, sin, and human frailty, many marriages fall short of the divine ideal; thus divorce occurs. When asked to explain divorce, Jesus pointed out that divorce in the Old Testament was permitted in response the hardness of people's hearts, not because God was in

favor of divorce; therefore divorce is an unfortunate exception due to humanity's inability to forgive and live in covenant agreement (Matt 19:8). The controversy over whether divorce and remarriage is allowed according to the Bible revolves primarily around Jesus' words "except for marital unfaithfulness" found in Matthew 5:32 and Matthew 19:9. Many Christians hold this exception as the only thing in Scripture that possibly gives us permission for divorce and remarriage. The Church of the Nazarene is one of them; their manual states, "though there may exist such other causes and conditions as may justify a divorce under civil law, only adultery is a scriptural ground for divorce and only adultery will supply such ground as may justify the innocent party in remarrying" (Church of the Nazarene, 1989). Many biblical interpreters understand this exception clause as referring to "marital unfaithfulness" during the betrothal period. However, in Jewish custom, a man and a woman were considered married even while they were still engaged, as was the case between Joseph and Mary. However, the Greek word translated "marital unfaithfulness" is a word which can mean any form of sexual immorality. It can mean fornication, prostitution, or adultery. Most likely Jesus is possibly saying that divorce is permissible if sexual immorality is committed. Sexual relations is such an integral part of the marital bond, "the two will become one flesh" (Gen 2:24; Matt 19:5; Eph 5:31), that a violation in this regard would be considered very serious. Therefore, breaking that bond by sexual relations outside of marriage is probably universally permissible as a reason for divorce.

Some scholars understand 1 Corinthians 7:15 as another exception, allowing remarriage if an unbelieving spouse divorces a believer. However, the context does

not mention remarriage but only says a believer is not bound to continue a marriage if an unbelieving spouse wants to leave. Some conservative views fail to find provision for abuse as a valid reason for divorce. It is obvious that God despises the mistreatment of wives by their husbands (Col 3:19; 1 Pet 3:7; Eph 5:25-33). Abuse should not be tolerated by anyone. No one should have to live in an abusive environment, whether it is with a spouse, family member, friend, employer, caregiver, or stranger. Physical abuse is against the law, and the authorities should be the first ones contacted if this occurs in a home. The American Bar Association statistics on domestic violence are hard to ignore: "In a 1995-1996 study conducted in the 50 States and the District of Columbia, nearly 25% of women and 7.6% of men were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or dating partner/acquaintance at some time in their lifetime" (American Bar Association, 2007).

A spouse who chooses to abuse has violated their covenantal vows. Most of those who disagree with this position advocate separation but fall short of approving spousal or child abuse as biblical grounds for divorce. Such a stance keeps millions of victims unnecessarily at risk for continued abuse or death. Additionally, such a position weakens the church as an institution that protects the innocent. Such a position appears to protect the abuser rather than advocating for the sanctity of marital vows and protection from victimization.

Sometimes lost in the debate over the exception clause is the fact that it is an allowance for divorce, not a requirement for divorce. This helps us learn the third key in the process for change – forgiveness. "What makes some marriages last a lifetime,

while others falter and fall apart? According to Professor Douglas Kelley of Arizona State University West, the key to long-term conjugal bliss may be in how well a couple communicates forgiveness" (Forgiving.org, 2008). The Christian message advocates forgiveness (Matt 18:21-35). Adultery is a serious violation of the marriage covenant and is considered biblical grounds for divorce. However, growth is achieved through pain, and victory over pain is forgiveness. Christian counseling helps couples access God's grace. Through grace and forgiveness, couples can learn to forgive and begin rebuilding their lives and their marriages. God has forgiven us so much more; surely we can follow his example and even forgive the sin of adultery (Eph 4:32).

It is distressing that the divorce rate among professing Christians is nearly as high as that of the secular world (The Barna Group, 2004). The Bible makes it abundantly clear that God hates divorce (Mal 2:16) and that reconciliation and forgiveness are available and possible. God recognizes that divorces will occur, even among his children. A divorced and/or remarried believer should not feel any less loved by God, even if that divorce and/or remarriage doesn't meet the exception criteria. Divorce is not considered the unpardonable sin, and according to 1 John 1:9, God's forgiveness is available.

What does the Bible say about gay marriage/same-sex marriage?

In recent years, political and cultural pressures have increased significantly, requiring the Christian church to review its position on same-sex marriage. In February 2004 poll; Gallup (Gallup, 2004) reported that Americans are evenly divided on a constitutional amendment defining marriage as the union between a man

and woman. The Gallup Poll (Gallup, 2004) revealed about 6 in 10 Americans oppose the legalization of same-sex marriage, although less than half support the idea of a constitutional amendment that would define marriage as only between a man and a woman (Gallup, 2004).

Before discussing gay marriage/same-sex marriage, we first have to remember what the Bible says about homosexuality. The Bible clearly and consistently tells us the same message: homosexual activity is a sin (Gen 19:1-13; Lev 18:22; Rom 1:26-27; 1 Cor 6:9). We have to remember responsible behavior begins with choice, and blaming God by asserting God creates a person with homosexual desires is theologically absurd. A person becomes a homosexual because of sin (Rom 1:24-27) and ultimately because of his or her choice to indulge in a lifestyle that perverts the intended use of sexuality; they are considered sinners. Some may purport a person may be born with a greater susceptibility to homosexuality, just as people are born with a tendency to drink alcohol or other behaviors. Even if that is the case, that does not excuse a person from choosing to sin by giving in to sinful desires; it only explains biological motivation. But what about other motivating factors like choice? If a person is born with a greater susceptibility to anger or rage, does that make it right to give into those desires? Of course not! The same is true for homosexuality. Our society has already paved the way for homosexuality as a lifestyle of personal choice. Sanctioning or legitimizing homosexual marriage would be considered as granting approval of a lifestyle that the Bible clearly and consistently condemns as sinful. Christians should stand firmly against the idea of gay marriage/same-sex marriage. Marriage is ordained by God is designed to be between a man and a woman

(Gen 2:21-24; Matt 19:4-6). Homosexual marriage is a perversion of the institution of marriage and an offense to the God who created marriage for humanity's benefit. God forbids and condemns homosexuality, so he clearly is opposed to homosexual marriage. As Christians, we are to seek to share the love of God and salvation through Christ with homosexuals. We are to be loving and kind to homosexuals, while at the same time not condoning their sinful lifestyle as a legitimate alternative to the biblical view of marriage and family.

Like divorce, we also have to remember that homosexuality is just as forgivable a sin as all other sins. God's forgiveness is just as available to a homosexual as it is to an adulterer, murderer, and thief (1 John 1:9). God's love and desire to save extend to homosexuals (John 3:16; Rom 5:8). There is hope – God also promises the strength for victory over sin, including homosexuality, to all those who will believe in Jesus Christ for their salvation (1 Cor 6:11; 2 Cor 5:17).

Conclusion

When speaking about a theological basis for family relationships we need to be careful not to engage in the common practice of selecting certain Scriptures and arranging them as one would a with a flower arrangement to suit our needs. Being aware of biblical and theological positions on the various issues the Bible speaks to regarding marriage and family is invaluable. But without a thorough understanding of the elements that make family relationships work, helping families reach their potential will be nearly impossible. What is important for the Christian counselor is developing an understanding the family as a developing system, pinpointing blocks to

growth, and empowering the agents within the system to make the necessary adjustments to achieve greater intimacy, thus producing a stronger marital covenant.

A lot has changed in our culture over the last fifty years. These transitions include moving from a rural to an urban setting, from having home and church as our primary influence, to the media acting as the primary source of influence. The economy has changed; two parents working outside the home have now become the norm. The definition of marriage has come under attack, and the marital roles that were once clear have now become confused. Our children are now exposed to a global world and are often the forgotten victims of sociological change. It is tempting during times of change to select hard-and-fast rules for family life; however, it is nearly impossible to maintain rigid of marital roles or the expectations of family life in the 1950s. Biblical principles are just that, principles, a guide to help us to achieve a marriage and family that is fulfilling for its members, and one that glorifies God. The answer is not the role-less marriage that is so common place today, nor is it the Ozzie and Harriet roles of yesterday. Marriage and family are about healthy communication, marital commitment, proactive parenting, and the giving and receiving of forgiveness and grace as the Bible teaches.

CHAPTER 3

LITERATURE REVIEW

Introduction

The purpose of this literature review to explore the theoretical orientations employed in the Smith case study, the subject of this thesis project. This literature review will outline the various researches that have been conducted in family systems theory, structural family therapy, cognitive-behavioral therapy, and solution-focused therapy. It is also proposed that this literature review will offer some recommendations based on the synthesis of the information provided, in hopes of improving clinical outcomes in family therapy.

For the purpose of discussion, this literature review will be used to formulate a rationale for clinical therapy. This literature review will answer the question regarding specialization or eclecticism concerning therapeutic approaches. Recent journal articles and books on the subject will be consulted to support the recommendations in the discussion section.

Christian therapists, like others in the counseling field, derive interest in family therapy from a concern about the effects that divorce and dysfunctional families have on society. This literature review will provide an overview of recent scholarship on the various theoretical orientations used in the case study required for this thesis project and evidence-based research outlining therapeutic outcomes.

Recent Scholarship

Solution-Focused Counseling

Judging from the literature, solution-focused counseling (SFC) has gained recognition in the field of psychology over the past two decades. The appeal of SFC is that it offers a respectful approach to counseling and regards the cultivation and utilization of client resources (i.e., strengths, abilities, intrinsic motivation) as the keys to positive change. The tenets of SFC are primarily rooted in person-centered counseling and might be considered reactions to, or the antitheses of, problem-focused types of therapy. They represent, therefore, paradigmatic shifts in how clients are conceptualized, the counseling process, the counselor's role, and client participation in counseling (Lewis & Osbourne, 2004). However, in the *Theoretical Models of Counseling and Psychotherapy* the authors stated, "SFC has been criticized for its lack of an empirical research base" (Eckert, 1993; Fish, 1995, 1997; S. D. Miller, 1994; Shoham et al., 1995; Stalker et al., 1999) despite its more than 20 years of practice. Most of the studies reporting the effectiveness of SFC have been promulgated by its founders, clinicians at the BFFC in Milwaukee, Wisconsin, and students of the BFTC training center. These reports are "substantiated solely by reference to subjective clinical experience" (S. D. Miller, 1994, p. 21) and are often presented in anecdotal form (Linton, 2005).

Critics of SFC note, "Care must be taken, however, that there not be a rush to formulate solutions or that only 'solution talk' be permitted" (Lewis & Osborn, 2004). The characteristics of the solution-forced therapist described by Nylund and Corsiglia (1994) echo concerns that SFC neglects problem elicitation (Kuehl, 1995)

and clarification (Fraser, 1995, 1999), as well as client history and broader assessment (Stalker, et al. 1999), which may contribute to a tendency to adopt an either/or view of solutions (Walter & Peller, 1994).

Cognitive-Behavior Therapy

Many people find the distinctions among behavior therapy (BT), cognitive therapy (CT), cognitive behavior modification (CBM), and rational emotive behavior therapy (REBT) confusing (David & McMahon, 2001). Despite the intricate distinctions between these cognitive schools of thought, cognitive-behavioral therapy is one of the more prominent therapeutic modalities in social work practice (Hepworth, et al. 2006). This modality, pioneered by people such as Beck (1976) and Ellis (1996), focuses on identifying unhealthy thought patterns that underlie unproductive behaviors, which are then replaced with more salutary schema that foster enhanced functioning. A substantial body of empirical evidence attests to the effectiveness of traditional cognitive therapy and, consequently, has been used to assist clients wrestling with a wide variety of problems, inclusive of anger, anxiety, phobia, stress, and, perhaps particularly, depression (Beck, 1995; Chambless & Ollendick, 2001; Hepworth et al., 2006). A review of the experimental literature by a task force established by the American Psychological Association (David & McMahon, 2001), demonstrated the effectiveness of CBT for adults. In their review, CBT was efficacious for depression, generalized anxiety disorder, social phobia, obsessive compulsive disorder, substance abuse and dependence, agoraphobia, and panic disorder (DeRubeis & Crits-Christoph, 1998). The success of cognitive

approaches has been remarkable. Clinicians and researches have noted that cognitive approaches have assumed a major role in the contemporary psychotherapy. Cognitive sciences seem to be producing the most promising sources of theory among the different systems of psychotherapy (David & McMahon, 2001).

CBT's popularity and pervasive integral nature has also made CBT attractive to Christians and to those who work with children and adolescents. Recent research shows spiritual principles are also being integrated with CBT, thus creating spiritually modified cognitive-behavioral therapy (Hodge, 2006). Treating children with emotional and behavioral disorders using CBT has recently been receiving more research and clinical attention (Eisen, Kearney, & Schaefer, 1995; Jayson, et al. 1998; Kendall, 1991; March & Mulle, 1998; Reincke, Ryan & DuBois, 1998). We know that children, as well as adults, with psychological problems make the same systematic errors in thinking (cognitive distortions) and have skill deficits that maintain their problems. Research suggests "the fundamental principles of CBT that apply to adult disorders can be applied to children, of course, with developmental modifications" (Dia, 2001).

Systems Theory

General systems theory (GST), on which family systems theory is based, is a conceptual approach that has emerged most notably in the second half of the twentieth century. The term system refers to "a set of elements standing in interrelation among themselves and with the environment" (von Bertalanffy, 1975, p. 159). Researchers and theorists have applied this theory to study systems in a variety

of fields, which include families, biology, communication, and organizations. The general view is that the level or unit of analysis within systems theory is the system itself, particularly when focusing on relationships and interactions within a family system (Broderick, 1993). With systems theory, the smallest appropriate unit of analysis is not an individual's behavior but an interactional sequence involving a pattern of exchange that occurs between individuals—in a word, the unit of importance is the system of members in mutual and interdependent relationships with one another, not individual behavior in isolation of context" (Jurish & Myers-Bowman, 1998).

Bowen's family systems approach is relevant to the structural context of pathology noted in families. Like other family system thinkers, Bowen proposed that all families can be characterized on a continuum of differentiation levels (Coco & Courtney, 1998). Researchers of family systems theory are finding its principles are also useful in the workplace. "Especially helpful are conceptual tools such as homeostasis and triangulation. Homeostasis helps social workers understand why problems seem to come from nowhere and keep repeating themselves" (Tolley, 1994). There are other useful concepts from family systems theory: family rules, family myth, and family secrets. Family rules are customs that define roles, power structures, and communication patterns. A family myth is a shared belief among all family members that results in automatic agreement without further thought or discussion. A family secret is a characteristic of a family member or an event in the family history that is not discussed within the family or outside it.

Structural Theory

Structural family therapy has a small, long-standing base of empirical support, almost exclusively in family therapy (Gurman, et al., 1986). Most recently, research on structural interventions is best represented in the integrative work of Szapocznik, Liddle, and associates. Strategic therapies have seldom been assessed and, therefore, have received limited support (Lebow and Gurman, 1995). The structural approach emphasizes family organizations composed of subsystems and focuses on boundaries between subsystems. Structural therapists focus on resolving structural problems in the family, whereas strategic therapists focus on the presenting symptom (Sexton, et al., 2003). The structural family therapy model provides a framework and specific techniques for the practitioner to assess and intervene around the family's boundaries, rules, roles, and subsystems. In summary, these models compliment one another very nicely (Springer & Orsbon, 2002).

In a study of structural family therapy, Szapocznik, et al. (1989) examined the efficacy of structural family therapy, psychodynamic child therapy, and a recreational control condition with Hispanic children 6 to 12 years of age. Based on prior work, Szapocznik and colleagues reasoned that structural family therapy is well suited for this population because of the match between the values of the structural approach and the value orientations and interpersonal style of preference by Hispanics (Szapocznik et al., 1978; Szapocznik et al., 1990; Szapocznik & Kurtines, 1989). In other words, the values inherent to the approach itself were thought to be congruent with the population in question and thus culturally sensitive (Guillermo, 1995).

Discussion

According to the U.S. Department of Labor and Statistics, labor statistics reported 2006 revealed that counselors held about 635,000 jobs and psychologists, 331,900 (U.S. Department of Labor, 2008). Labor trends indicate the employment of psychologists is expected to grow 15% from 2006 to 2016, and employment of counselors is expected to increase by 21% between 2006 and 2016. Current statistics suggest that employment will grow because of increased demand for psychological and counseling services in schools, hospitals, social service agencies, mental health centers, substance abuse treatment clinics, consulting firms, and private companies. With the demand for individual and family counseling increasing, how do we determine if the outcome of treatment is positive or negative? How do we know which therapies work? What makes therapy successful? More importantly, with more than 400 types of psychotherapy available, ranging from the highly effective to the highly questionable to the downright fraudulent, the task of choosing a therapist can be daunting (Beutler, et al., 1998). Many therapists advertise that they are certified cognitive therapists; another is a psychoanalyst; others may be Jungian or a graduate of the Gestalt Therapy Institute. What does this mean, and does it make a difference?

We know from the research literature that psychotherapy is effective and that empirical studies have been done to support the various modalities currently being utilized. Research designed to compare the effects of different types of psychotherapy can be divided into two categories: clinical trials and naturalistic studies, or research on therapy efficacy versus effectiveness. Comparative studies are difficult to find, but those studies that have been conducted have revealed interesting results. A number of

authors have argued that the interventions studied in efficacy research do not accurately represent psychotherapy as it is practiced in the real world. First, practicing therapists rarely use treatment manuals; instead, most clinicians are theoretically eclectic and flexible, combining diverse techniques in their work with individual clients (Shapiro, et al., 1997).

If therapists embrace an eclectic approach despite their formal training, and if clients have multiple problems that extend beyond their primary diagnosis, an eclectic approach can be helpful in assisting clients in symptom relief, thus improving general life functioning. For the sake of positive clinical outcomes, it is important for therapists of all pervasions to keep abreast of research findings, translate research findings and developments as they apply to clinical practice, prioritize techniques and intervention models, and re-examine funding priorities and research foci (Wilson, et al., 1996).

As stated earlier, one of the roles of this literature review is to discover integral parts of the therapeutic process that promote positive clinical outcomes. Is it the theoretical orientation? Does an eclectic approach produce better outcomes? Recent studies suggest "therapists are led by theories of behavior that they often take on faith. And like their patients, these private theories do affect their practices" (Beutler, et al., 1998, p. 74). Many of the popular models of psychotherapy that followed in the footsteps of classical Freudian theory tended to emphasize the differences between client and therapist. As such, the disparity between both parties is arguably entrenched in most, if not all, psychotherapeutic approaches. To help us understand the therapeutic process and find an answer to the questions regarding

clinical outcomes in therapy, recent scholarship states, "there is also no such thing as a therapist and no such thing as a patient – only a patient-therapist system, with each individual reacting and influencing the other in myriad overt and subtle ways. These ideas suggest that the manner in which the therapist structures the environment can demonstrate and reveal to the patient the type of relationship that the therapist intends both explicitly and implicitly to establish with the patient" (Holmes, 1998, p. 32). It appears a therapist's approach to psychotherapy concerning his theoretical orientation is important, but the most salient aspects of the therapeutic process reside in the therapeutic relationship and the therapist's capacity to offer the patient a clearly defined therapeutic framework. Therefore, it should be noted that modern therapy has shifted its emphasis to focus on the interpersonal field of client – therapist communication and on the mutual influence each has on the other within the therapeutic relationship. The therapist and the patient are now seen as participating in a continuous ongoing feedback loop, with each influencing the other (Kahn and Fromm, 2001).

Recommendations

In *Am I Crazy, or Is It My Shrink?*, the authors highlight the problems therapists and clients face in their therapeutic process: "It is only a modest overstatement to say that each therapist offers a treatment that is consistent with the therapist's theory, regardless of what the patient's problem is" (Beutler, et al., 1998, p. 51). The Department of Psychology at the University of Utah offers the following recommendations for therapists (Wilson, et al., 1996).

Family therapists can and should enhance and maintain professional competence through keeping abreast of research findings and developments in the field (American Association for Marriage and Family Therapy, 1991). This can be accomplished, in part, through reading current research literature and attending professional conferences, which includes training in ethical issues through workshops, seminars, and in-service training. Therapists must also scrutinize themselves regarding their honesty, competency, stereotypes, and biases, and update dated ethical standards (Patten, Barnett, & Houlihan, 1991).

Family therapists should translate research findings and developments as they apply to clinical practice. From an ethical perspective, therapists need to include both theory and research as a basis for their practices. Without a theoretical foundation, practitioners are left with little rationale for formulation of therapeutic goals and for developing techniques to accomplish these goals. However, just as some practitioners have little use for theory and are impatient when it comes to articulating a theory that guides practice, others do not see the practical application of research. Furthermore, without understanding how to translate current research findings into their practices, therapists have little basis for deciding what techniques to use with different clients. Thus, an appreciation of how theory and research can enhance how therapists function may result in ethical and effective practice (Corey, Corey & Callanan, 1989).

Therapists should prioritize techniques and intervention models that have been shown to be of value through empirical scrutiny. One method of scrutinizing these interventions is through the utilization of meta-analytic strategies because it addresses the outcome equivalence question with more precision than the traditional narrative

review. Another method is through qualitative and quantitative research on specific therapeutic sequences and other phenomena. For example, such studies as the classic Patterson & Chamberlain (1992) process examination of the effects of therapies "teach," while not necessarily linking directly to outcome, and can inform therapists with respect to the timing and effects of common therapist behaviors – some of which at times can produce unwanted effects. In our Functional Family Therapy (FFT) lab, for example, different family members respond in importantly different ways to therapist reframe and other therapist maneuvers (Robbins, Alexander, Newell & Turner, 1996). Similarly, Newberry, Alexander, and Turner (1991) found important differences in family member response to therapist gender and specific therapist techniques. Unfortunately, therapists who are not aware of such findings are vulnerable to other interpretations of family member behaviors, such as ascribing motivational deficiencies to some or all family members. Given the high dropout rates in many high-risk samples, which research tells us can be reduced dramatically when informed by solid theory and well-conducted research (Szapocznik, et al., 1988), we believe it can be considered unethical for clinicians to remain uninformed by such information and continue practices that leave families at risk.

Finally, researchers and funding sources must reexamine funding priorities and research foci. Many scientific findings, while representing the highest standards of *good science,* are not in a form that clinicians can use. Clinicians must deal with complex phenomena on a case-by-case basis, and they view researchers as ignoring most of these complexities by invoking exclusion criteria or conceptualizing subtleties as error variance. Instead, research priorities must include clinical utility on

a par with scientific purity. Hetherington (1989) and Gurman, Kniskern, and Pinsof (1986), among others, have suggested the inclusion of more contextual issues and reconsideration of the process-outcome dichotomy in the family therapy research enterprise. Such suggestions will not only enhance the appropriateness and theoretical richness of family therapy research, but also will bring to the forefront more of the questions that are relevant to practicing family clinicians.

Conclusion

Research on couple and family therapy has focused on the effect of therapeutic approaches on specific disorders and problems. Research has demonstrated powerful connections between family processes and various maladies. Couple and family therapy have begun to emerge as effective strategies in treating a wide array of specific problems (Lebow & Gurman, 1995).

Hundreds of diversified therapies are being practiced that have not been subjected to scientific scrutiny, while other therapies are backed by empirical research. Nevertheless, clinicians have an ethical responsibility to recognize and implement therapeutic interventions that are evidence-based rather than succumbing to ethical dilemma, frustration, and complacency. The translation and implementation of qualitative and quantitative research findings of clinical practice encourages accountability to professional competence and will help dispel confusion that exists in certain therapeutic approaches. More importantly, because we know that in general family therapy works, even if we do not clearly understand how it works, we must

demand more research with greater attention to the complexities and subtleties faced by clinicians.

This literature review has explored multiple theoretical paradigms. According to available research, an eclectic approach to therapy can not only be encouraged, it may be the most popular approach to therapy. The approaches discussed within this review are congruent with my personal philosophy and personality style. Furthermore, this literature review has highlighted the importance of ethical and professional growth and guidelines.

Concerning the integration of these therapeutic into clinical practice, Systems theory and structured therapy formed the basic counseling paradigm concerning the conceptualization of the Smith Family case study and the intervention plan. Clients and the families they belong to are neither linear nor static. Therefore, Systems theory helps the counselor move away from micro-counseling, to looking at the entire family system, including boundaries, roles, hierarchy, and triangulation within the family. Similarly, structured therapy helps in identifying the family's strengths and weakness. Additionally, structured therapy's goal-oriented process and its focus on structural problems in the family assist in creating meaningful treatment plans that are easy to follow and implement from both the clinician and client perspective.

Therapy can sometimes be overwhelming. Solution-focused counseling is normally brief in nature, but it also allows the client and counselor to focus on small changes and on solutions. With limited and predetermined number of sessions, solution-focused counseling provides a manageable plan of care that is easy for the

client to follow and aids in reducing client resistance to making a commitment to counseling.

Additionally, Cognitive-behavioral therapy provides the framework for a learning model for counseling. As such, Cognitive-behavioral techniques are utilized within the aforementioned paradigm to assist the client in learning new behaviors by shaping, clarifying, or restructuring personal values and core beliefs in hopes of alleviating negative thoughts and feelings. Therefore, the use of homework and other cognitive aids is a major feature in the counseling to assist in replacing faulty learning, incorrect inferences, or incorrect information by reinforcing positive thought processes through lesson plans designed around solutions created by the client in collaboration with their counselor. Combining the strengths of these approaches for brief clinical interventions seems to work well.

CHAPTER 4

THE SMITH FAMILY – CASE STUDY

Case History

The following case study describes the Smith family. In this chapter, a complete description of the family will be given, including a genogram. This chapter will also offer a comprehensive history and analysis of the relationships and the presenting concerns. Last, a comprehensive conceptualization of the individual problems facing the primary dyad will be discussed as a prerequisite for the development of a treatment plan.

This case study has been derived from a case encountered in pastoral counseling. This case deals with a married female adult dealing with an early childhood trauma – sexual abuse. The family system includes a married couple with three children. The case characteristics also include cultural issues, as the family is Filipino. This case required this writer to do some research on childhood sexual abuse and investigate cultural nuances that may cause roadblocks in therapy. These issues will be discussed in detail at the end of this chapter. Appropriate measures have been taken to disguise the identity of the persons and circumstances depicted herein. Though not stated in the case study, clinical supervision was given throughout the course of counseling.

Kim (Wife)

Kim contacted me for counseling, at the request of her employer for depression and poor interpersonal social relationships. During her initial consultation, it was revealed that Kim is 49 years old. Kim and her husband immigrated to Bermuda ten years ago with her husband and two children; her oldest child, a girl, stayed in the Philippines with Kim's mother to finish school.

Kim is the oldest of four siblings; her siblings include three sisters and a brother, who is the youngest. Kim indicates that her father was a hard-working man who was the primary source of income for her family. Kim was close to him while she lived at home. Kim also revealed she had a close relationship with her mother, who she described as very religious. Kim recalls that it was her mother who ensured that she and her siblings attended Catholic Mass every week. Kim described her home environment in the Philippines as a family compound which housed her extended family of uncles, aunts, and cousins. With tears and a little hesitation, she began to disclose that when she was 8 years old, her maternal uncle sexually molested her over a four-year period. Her memories of the violation contained specific details with corresponding feelings and emotions of shame, anger, regret, and self-blame. Kim revealed that the abuse stopped when her family moved out of the compound to another province when she began high school. She also revealed that was the second time she shared her story; the first was with her employer after a depressive meltdown at work. Though she has been married for 27 years, her husband and family are unaware of the secret and shame she has been hiding.

Kim has been married to Alonto for 27 years. They met in high school and married shortly after graduation. They have two daughters, one of whom is married and lives in the Philippines. The other attends college in Canada. They also have a 10-year-old adopted son, also of Philippine decent. Kim reports that she has a good relationship with her husband and her children.

Kim enjoys working in her garden but would like to entertain her friends more if she was not so preoccupied with worry. Kim denies any problems with use of alcohol or other mood-altering drugs. There is no history of substance use disorder in her family of origin. Kim and Alonto live alone in their own home with their son. Alonto is employed as a chef at a local hotel. Kim has been working as a live-in care giver for 10 years but will be ending her relationship with her employer in 3 months due to stress and her personal issues. She denies any significant financial problems, but she does worry about their ability to retire; she would like to relocate to the Philippines, where the cost of living is less. She and Alonto attend church services quite regularly, but she fears that God does not hear her prayers for peace of mind. Kim has never been in counseling before. Kim has recently been prescribed Xanax by her physician, Dr. Cole. Kim complains of severe pain in her back that has been with her for two years, possibly from a slip-and-fall accident while on vacation two years ago. She has been told that surgery will not help. She worries that it may be something serious like cancer that has not been found.

Kim reports that her husband is very loving and supportive. However, she feels unattractive and avoids sexual intimacy when she can. She realizes this causes some tension with her relationship with her husband. When she does engage in sex,

she prefers to remain partially dressed with the room dark. By her account, she and her husband's sexual frequency have always been moderate/low. Usually, intimate encounters occur two or three times per month, but in the last year sexual intercourse has declined to once a month.

Alonto (Husband)

Alonto is 51 years old, younger than his two siblings, both females. Alonto's sisters are both married with children. Alonto was born in the Philippines to a middle-class family. Alonto reports that both his parents are deceased. Concerning his parents, Alonto stated that they had a good marriage and that he and his sisters enjoyed a close relationship. Alonto's father worked as a mechanical engineer until his retirement, while his mother worked in the hospitality industry. Alonto said his interest in cooking came when he visited the hotels with his mother. Alonto described himself as outgoing and sociable. When not working, he enjoys traveling or engaging in hobbies that require physical activity. Alonto is in good physical shape and leads an active lifestyle.

Alonto did not report any major issues concerning childhood trauma, or issues that may be considered clinically significant. Following high school, he traveled to Australia, where he trained as a chef before returning to the Philippines to work. Alonto and Kim married at 21 and 19 respectively, while Alonto was in training. Alonto and Kim have been married for 27 years. Alonto and Kim have three children: Analyn, 23; Catherine, 21; and Jayson, 10 (adopted). The couple also had a miscarriage shortly after Catherine's birth. Both Alonto and Kim are Catholic. Both

Alonto and Kim report that the first few years of their marriage were typical, with few problems that they can remember, even following the miscarriage. Kim suggests that most of their problems began to surface when their youngest daughter was in high school. During that time, Alonto traveled often, while she struggled with two teenagers and a young son.

When a job opened in Bermuda in 1997, Alonto immigrated to Bermuda. Kim, Catherine, and Jayson followed a year later. Analyn stayed behind in the Philippines. Alonto and Kim live in an apartment provided by Kim's employer in an upper-class neighborhood. The pair is experiencing marital problems that have caused them significant stress and are seeking counseling to assist in finding solutions for their marital discord.

Alonto has recently learned that Kim was sexually molested by a maternal uncle and is struggling with the implications of this recent revelation. He has expressed anger and regret regarding Kim's secret and is apprehensive of involving the children or of Kim confronting her family. He is aware that Kim has been in therapy with this counselor for depression and marital problems and was supportive of her during this period.

Throughout their marriage, Alonto has been aware that Kim felt unattractive and that she avoided sexual intimacy. Alonto reported that intimacy issues have caused some tension within their relationship. Alonto reported that Kim does not initiate sexual encounters, and he has always been curious about her need to remain partially dressed with the room dark when they have sex. By his account, Kim's

libido has always been low, and in recent months their sexual encounters have decreased to once or twice a month.

Alonto feels he has a good relationship with his children, despite his displeasure with his older daughter's marriage and his disappointment with Catherine's relationship with a Jewish American. Despite Alonto's busy schedule, he actively participates in Jayson's life, which includes soccer and attending parent-teacher meetings. Though Jayson is adopted, Alonto considers Jayson to be his legitimate son.

Analyn (Oldest Child)

Analyn, age 23, is married, and has a two-year-old son. Analyn married Julius at age 19, after a brief romance during a Catholic singles retreat. Little is known about Julius; however, Analyn mentioned that Julius is two years her senior and is from Legazpi City, in the Philippines. Julius's parents never married. Julius works at the Honda assembly plant in Legazpi City.

Analyn works at the upscale Misibis Resort in Legazpi City as coordinator of concierge services. Apparently Legazpi City is one of the Bicol Region's top tourist destinations thanks to its proximity to Mayon Volcano, one of the Philippines' most famous volcanoes, and Donsol, Sorsogon, the site of one of the world's largest annual migration of whale sharks. Analyn described her marriage in positive terms and remarked that their sudden marriage was the result of "love at first sight."

Analyn was hesitant to talk about her relationship with her parents. Apparently, her parents were not supportive of her sudden marriage to Julius; however, she stated

their relationship has improved since the birth of her son, Michael, two years ago. Prior to Michael's birth, she talked to her parents infrequently, usually once a month. Since Michael's birth, Analyn and her parents have increased the contact, and they have visited each other twice over the last two years. Analyn attributes some of the strain in their relationship to the distance between them.

Analyn did reveal that she has a closer relationship with her father than with her mother, and she thanks her father for helping her with her career in hospitality. Unlike her sister and brother, Analyn did not move to Bermuda when her parents immigrated. At her request, she lived with her maternal grandmother in the Philippines while she finished school. Concerning her childhood, she complained that her mother was overprotective and that her mom's expectations of her were unrealistic, and because of this, she naturally gravitated toward her father for emotional support. Analyn also shared that though she loves her sister, they are as different as night and day. She described her sister, Catherine, as outgoing, adventurous, and spoiled. When questioned why she described her sister as "spoiled," Analyn gave detailed stories how Catherine was allowed to engage in activities as a young adult that she couldn't at the same age, and how her parents constantly provide Catherine with money.

When asked to talk about her thoughts about her parents' marriage, she declined to comment. Analyn wants to remain supportive of her parents and be kept abreast of their progress, but she doesn't want to be involved the process. Analyn stated, "I don't want to sound selfish, but right now I'm busy building my own marriage and

raising my son. I can't afford to be distracted. It would be unfair to Julius and Michael. Ask Catherine."

Catherine (Middle Child)

Catherine is a 21-year-old college student. Currently Catherine is studying social work at a Canadian university. Apparently, Catherine is the classic extrovert. She is enthusiastic about life, likeable, and surprisingly nonjudgmental. Like most extroverts, she can be very spontaneous and impulsive, which seems to be the reason she ended up in Canada, and with a Jewish boyfriend, Nathaniel, from New York.

Catherine is expected to graduate next year and is not planning on returning to the Philippines. Catherine appreciates and is proud of her Philippine heritage but has fallen in love with Western culture and feels the opportunities that Canada and the United States offer are to good to pass up. Catherine's boyfriend of two years attends the same institution and is studying computer information systems. Neither Catherine nor Nathaniel attends church but believe faith and religion are important. Though she states she loves Nathaniel, Catherine has no immediate plans to get married and is unsure if she will get married at all.

Catherine was eager to talk about her childhood. Most of her discussions about her childhood were about happy times. Catherine's recollection of her childhood seemed to repaint what really happened, given her fixation on positive memories. Nevertheless, Catherine said she enjoyed the few years she lived in Bermuda with her parents and brother; however, she did admit she missed her sister, and that being separated from her was difficult. Catherine described her relationship with her sister

in positive terms, was excited to hear about her marriage to Julius, and was glad she was able to participate in her sister's wedding. When asked why her parents did not approve of her sister's marriage, she remarked, "My parents are old-fashioned; they were upset because they didn't know Julius or his family."

When Kim informed Catherine about her childhood sexual abuse, Catherine became irate. She has had extensive conversations with her mother and her sister regarding how Kim should handle her situation, including contacting a lawyer for advice in pressing charges. Since then, Catherine has refused to speak to her family in the Philippines.

Jayson (Youngest Child – Adopted)

Jayson presented as bright and pleasant and in many ways a typical ten-year-old. Jayson enjoys soccer and is doing well in school. He is aware that he is adopted and felt comfortable talking about his birth parents. Jayson revealed his father is deceased (car accident) and that his mother allowed him to be adopted after being diagnosed with multiple sclerosis. (Kim and Alonto confirmed Jayson's account and further added that Jayson's parents were known to them and their relationship with Jayson began when he was born.)

Jayson is unaware of the specific issues facing his family. However, like the other members of his family, the stress is undeniable. Kim and Alonto have spoken with Jayson's teacher and school counselor. To date, Jayson's behavior and academic performance has changed.

Relationship Analysis

The following section provides an analysis of the emotional relationships within the Smith family. A genogram and ecomap are also provided to give an in-depth pictorial view summarizing and illustrating familial relationships and patterns of behavior within the Smith family. The genogram will be used to support other measures used for family assessment and the creation of an intervention plan.

Marital Dyad

The initial analysis of the marital dyad is pictorially illustrated the following ecomap as strong connection. Despite the recent stress in the relationship regarding the revelation of Kim's prior sexual abuse, and Alonto's dissatisfaction with the level of intimacy, Alonto and Kim are committed to the marriage and each other. Though Alonto does not attend church as often as Kim would like, Alonto recognizes the importance and benefit of Kim's faith regarding her emotional well-being and ultimately their relationship.

Initially it is difficult to ascertain the effect Kim's progress with dealing with her past will have on her marital relationship. Furthermore, other unknown factors will include the additional stress stemming from their parental relationships and their connection with their family in the Philippines. Communication and conflict resolution skills will be necessary be required to strengthen their positive connection to one another. Associated stressors facing Alonto include employment demands and the potential loss of income due to Kim's loss of employment in a few months, and these concerns will need to be addressed in counseling. Expectations regarding

marital and family relationships can be overwhelming, so additional clarification will be sought.

Parent and Child Relationships

Alonto and Kim insist that they love their children equally and are unsure why Analyn feels the way she does. Misunderstanding in parental relationships regarding partiality toward one child is hard to qualify, particularly if the child who is claiming inequity is trying to manipulate the relationship to gain leverage. Nevertheless, Alonto and Kim wish to improve their relationships with both their daughters.

There appears to be adequate communication between the parents and their two oldest children, and Analyn and Catherine have progressed without major incidents through the natural relationship changes with their parents from adolescence to adulthood. Catherine appears to have a closer relationship with her parents when compared with Analyn. Alonto and Kim attribute the relationship inequity to their decision to allow Analyn to stay in the Philippines to attend school. Though Analyn visited her parents during summer vacations or when her parents visited the Philippines, her absence from the family has had a negative effect on the parent-child relationship. Alonto and Kim have a loving relationship with their youngest child, Jayson. Though Jayson is adopted, he is loved and treated as if he were their biological son. An analysis of their relationship revealed appropriate boundaries, with no evidence of co-dependency or enmeshment.

Sibling Relationships

In many ways, the relationship between Analyn and Catherine seems typical of sibling relationships. In this regard, the sibling rivalry between Analyn and Catherine is not unusual. Both Analyn and Catherine have had to endure unnecessary comparison by their parents, which has only increased naturally occurring sibling rivalry. The genogram analysis portrays Analyn's and Catherine's relationship as tenuous/uncertain. Analyn is more inclined to view her relationship with Catherine as a win/lose relationship, so she has become somewhat withdrawn.

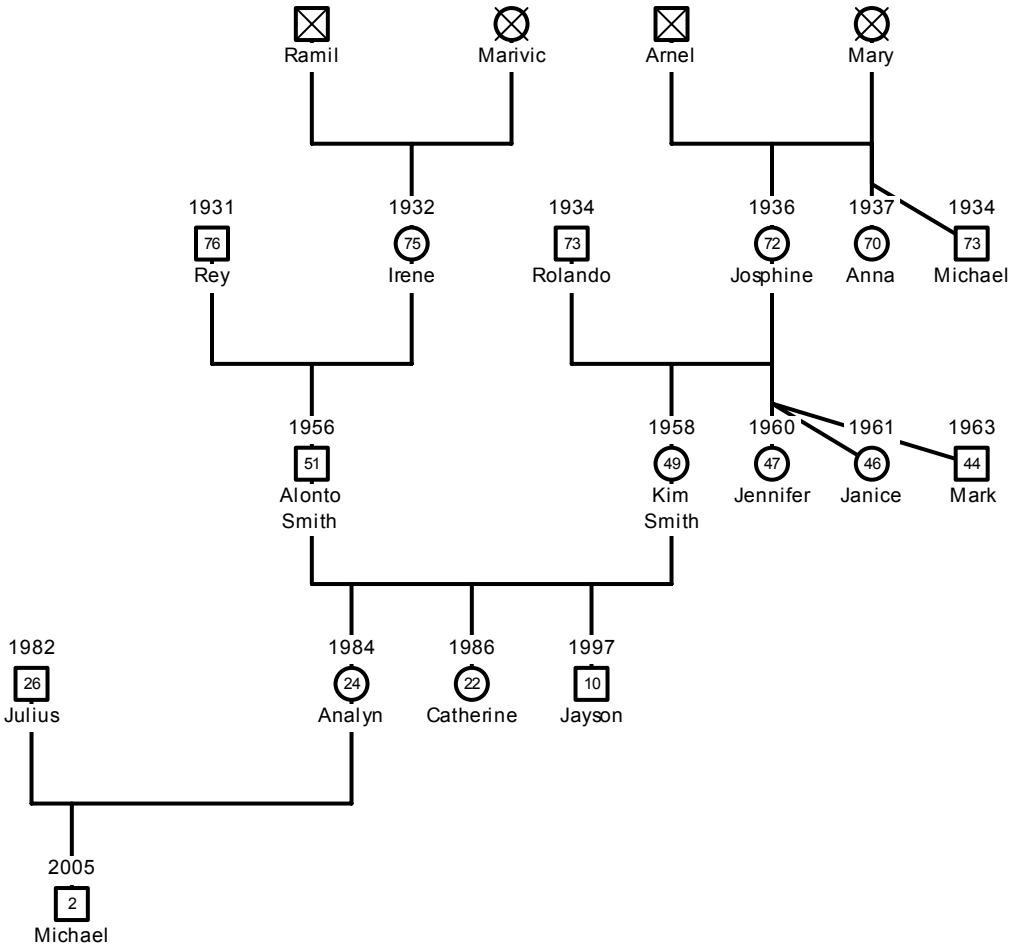
Despite low levels of estrangement, there exist between Analyn and Catherine positive feelings. Both are concerned about their mother and have expressed initial desires to address the perceived resentment and frustration that have existed for a number of years between them. Though their younger sibling is adopted, Analyn and Catherine have expressed love to Jayson in word and deed. Jayson likewise deeply appreciates his relationship with his older sister, has taken special interest in his nephew, and relishes the opportunity to be a big brother rather than an uncle.

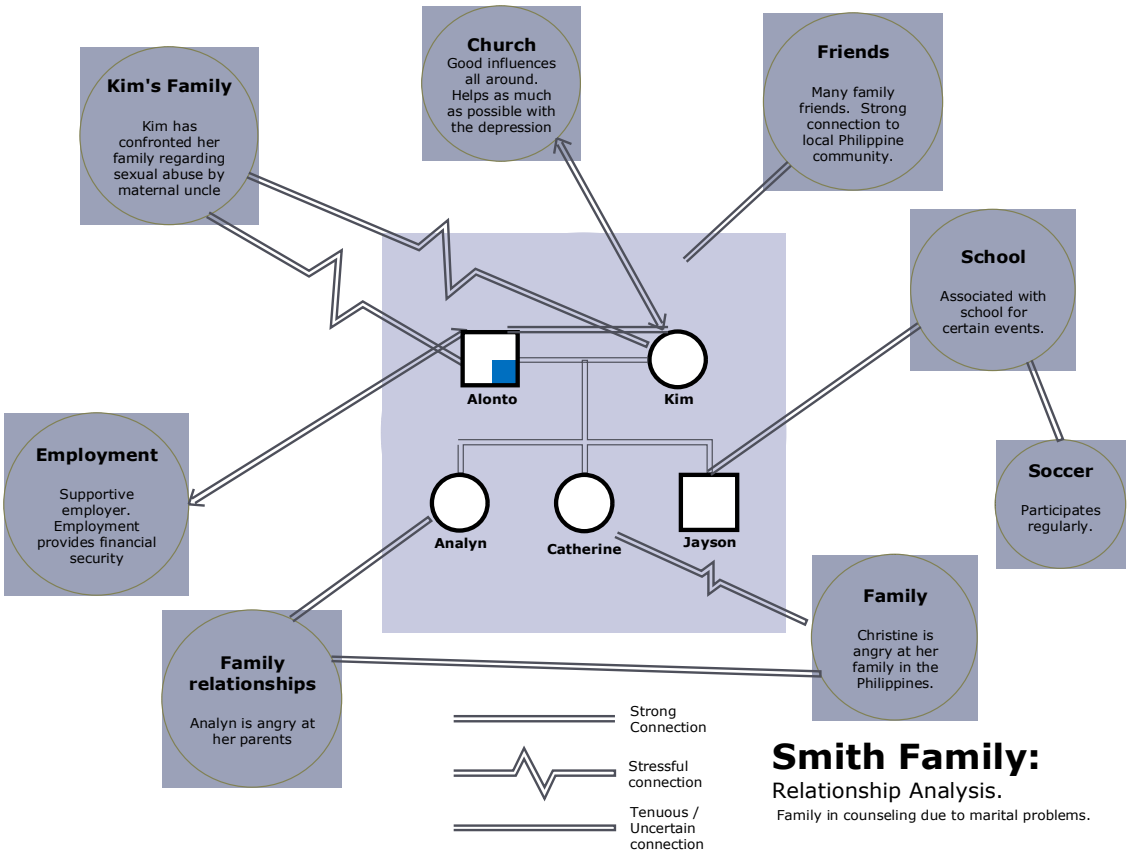
Kim's Relationship with Her Family

Recently, Kim's relationship with her family has become strained. Kim has recently engaged in counseling for depression and marital discord stemming from early childhood trauma (sexual molestation). With the encouragement and support of her husband and counselor, Kim and Alonto have decided to return to the Philippines to have a family meeting with her parents and siblings to discuss her hurt and to find the path to healing.

Recently, Kim found the courage to disclose her secret to her mother and write a letter to her uncle, which she plans to mail when she is ready. As anticipated, Kim's mother responded with a mixture of anger, guilt, and confusion upon hearing the news of Kim's sexual abuse. Kim has become reluctant to talk to her father and siblings about her abuse and is strongly reconsidering traveling to the Philippines as planned. Kim is fearful that if she shares her story with her parents and siblings, she will be rejected. To make matters worse, Kim has recently learned that her perpetrator (maternal uncle) has found religion and has joined the Catholic Church; and without Kim's knowledge, her mother reportedly approached her brother (perpetrator) with Kim's allegation of sexual molestation, which he denied. Upon receiving this news, Kim became angry and has expressed feelings of mistrust and betrayal, especially after informing her mother that she wished to wait for the family meeting before confronting her abuser.

Genogram & Ecomap





Problem Conceptualization

Sexual abuse is a worldwide problem for children and adolescents of both genders. Statistical reports reveal that more than half of all reported rape or sexual assault cases occur in people under the age of 16; approximately 25% are under the age of 10. More often than not, in more than 70% of the cases, the victim knows the person committing the abuse. The U.S. Justice Department found that family members or acquaintances committed 95% of all rapes of girls under the age of 12; 20% of this age group had been raped by their own father (Delgado, Lopez & Sebastiani, 1996).

An exact figure regarding the incidence of sexual abuse of children and adolescents is not available. Different studies have reported more than 38% of all women were sexually abused as children or adolescents. The ratio of abuse between girls and boys is about 2.5:1; more than twice as many girls are abused as boys (Green, 1993). Since reports of sexual abuse tend to be underreported, one must conclude the actual incidence of child and adolescent sexual abuse is significantly higher than these data suggest. At least 200,000 children and adolescents are sexually abused every year in the United States alone (Delgado, Lopez & Sebastiani, 1996).

Definition

Sexual abuse is defined as "a violation perpetrated by someone with power over someone who is vulnerable. This violation takes a sexual form and may include physical, verbal and emotional components" (Kidman, 1993, p. 9). Child sexual abuse is defined as "the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent" (American Medical Association, 1992).

Child Protective Services in most states define child sexual abuse as "contact between an adult and a child less than 18 years old in which the child is used for the sexual gratification of the adult." A parent or caregiver who allows such contact is considered to be sexually abusive even if that person did not commit the act. Furthermore, incest is defined as the sexual exploitation of a child by a family member but more commonly includes stepparents and relatives. Acts defined as

sexually abusive include “anal intercourse; oral-genital contact, fondling of the genitalia, anus, or breasts; and genital exhibitionism” (Green, 1993, p. 89).

Factors Affecting Impact on Victim

Studies have consistently revealed that adult female survivors experience far more psychopathology as adults when the victimizer was a close relative, that is, father, stepfather, or uncle, than when it was a stranger (Bower, 1993). These studies also seem to suggest females suffer more incidents of dissociation or multiple personality disorder when there has been long-term abuse. Child victims and adult survivors share the same symptoms of anxiety, depression, dissociation, and abnormal sexual behaviors. In many cases, the core symptoms beginning in childhood carry through to adulthood while a victim advances through life. Sometimes the symptoms disappear only to reappear at a later age. Further, new symptoms may occur in adulthood, such as substance abuse, eating disorders, and borderline personality disorder (Green, 1993).

Recent research indicates a connection between adult depression and childhood sexual abuse. The details of the research study indicate: Subjects: 1189 women were screened and 237 subsequently interviewed; 132 were depressed. Results: 49 (37%) of the depressed interviewees and 24 (23%) of the non-depressed interviewees reported experience of sexual abuse when they were under 16 years of age. A positive association existed between the more severe abuse and depression; all those who had experienced penetration were depressed as adults. A relation was also found between sexual abuse in childhood and sexual problems, housing problems, and

problems with their children at school. Conclusion: A positive association between child sexual abuse and depression was confirmed, but this was confined to more severe abuse (British Medical Journal, 1998).

While isolated incidents also cause trauma and psychological and behavioral problems, the intensity is greater when the child has been subjected to repeated abusive experiences (Bower, 1993). Besides dissociation, post-traumatic stress syndrome has been reported as a result of prolonged sexual abuse as a child (Rind & Tromovitch, 1997).

A family life that is already disturbed or chaotic has been found to heighten the impact of childhood sexual abuse. Additionally, when the abuser is a close family member, specifically a father, stepfather, or brother, more girls have been found to experience post-traumatic stress syndrome (Bower, 1993).

Effects on Victim

One of the most persistent and damaging attitudes in society is the determination to equate rape with sex. The literature suggests numerous psychological and behavioral effects are the result of sexual abuse, including, but not limited to, feeling vulnerable, unloved, worthless, and powerless; having difficulty distinguishing sexual from affectionate behavior; difficulty maintaining appropriate and clear personal boundaries, especially as related to their bodies; feeling unable to refuse unwanted sexual advances; an inability to trust; feelings of shame; mental health problems; initiating sexual relationships earlier in life; promiscuity; greater vulnerability to HIV/AIDS (Delgado, Lopez & Sebastiani, 1996); anger, depression,

deficits in intellectual, physical, and social development; phobic reactions (Green, 1993); eating disorders, post-traumatic syndrome; alcohol and drug abuse; low self-esteem; relationship difficulties; aggression; self-mutilation; suicide; dissociation (Rind & Tromovitch, 1997); nightmares and hyperactivity (Bower, 1993).

Green (1993) found that about 17% of preschoolers, 40% of school-age children, and 24% of adolescents met criteria for clinically significant psychopathology. Rind and Tromovitch (1997) found that harm was pervasive in all age groups as adults for those victims who have not been in a clinical setting: "consequences of early childhood abuse are far reaching and have been linked to the development of significant impairment in daily functioning and severe psychiatric and medical disorders" (Rind & Tromovitch, 1997, p. 81). Rind and Tromovitch (1997) also reported more female children and adolescents reported physical harm than did male victims.

Healing Process

Survivors of abuse have been deeply, horribly wounded. The very foundation of their lives has been destroyed, and they often ask the most basic question, "Why did this happen to me?" Sufferers often turn to religious leaders for answers. The Christian faith has a lot to say about healing. Faith allows victims to acknowledge that abuse has occurred and has caused great harm. In the Smith family case study, the victim has begun to blame God for her abuse and is doubtful she can be loved and forgiven. In this regard, a good Christian counselor should recognize that the healing process is a frightening experience. There is no short answer. However, the books of

Job and Lamentations illustrate that our human experience may involve pain, disappointment, doubt, and questioning. Their conclusions suggest that there are no easy answers to life's most difficult problems, but God is gracious and compassionate. However, it is helpful to know that we are not the first person to wonder or doubt, and that we will not be the last. The fact that Job and Lamentations are in the Holy Scriptures suggests that the Bible recognizes that doubt, pain, suffering, and crises of faith are all possible experiences for humanity. It is reassuring to know that God understands our human experience, that pain and crises are a legitimate part of our spiritual journey.

The healing process in this case study will be a long and difficult process, but it is hoped that with professional intervention, the victim will engage in the healing process. Both individual and later, group, therapy will be recommended in this case to allow the client an opportunity to learn from other survivors of childhood sexual abuse. The symptoms that accompany sexual abuse survivors do not simply vanish, even with therapy. At best, survivors will learn to deal with the different effects in a more constructive manner. Support groups have also been found to be helpful (Green, 1993; Bower, 1993) and will be relied on in this case.

Cultural Considerations

Due to global trends of rapid immigration, such as international migration of skilled workers, Bermuda, like many Western countries, has become a haven for multicultural families. The Smith family presented unique challenges, as their cultural

background had to be taken into consideration as it relates to their social, religious, and linguistic heritage.

Early interactions with the Smith family revealed that culturally competent family therapy required acute attention to culture-bound characteristics, such as the family's thinking and behavior prior to therapy and throughout the therapeutic process. When considering a family diagnosis that was culturally competent and subsequent treatment, the clinical assessments and interviews were geared toward locating and defining those parts of the family's way of relating and processing familial information that were problematic. If these cultural issues were considered to be insurmountable, ethical requirements mandated that the Smith family be referred.

Additional research articles were perused to assist with the conceptualization of this case, regarding sexual activity and function in middle-aged and older women and sexual behavior and dysfunction in adults of Asian countries. The Bermuda Filipino Association was also consulted for specific information about Filipino family life and challenges facing Philippine immigrants in Bermuda.

CHAPTER 5

THE SMITH FAMILY - INDIVIDUAL & FAMILY THERAPY

A week prior to Kim's initial consultation, Kim recalls having suicidal thoughts. After an emotional outburst at work, she reported driving her car to the beach, while parked, she recalls having a crying spell, and in the midst of gathering her thoughts, she contemplated driving the car into the water and drowning herself. After recounting this story to her employer, her employer suggested she contact her doctor. Upon contacting her primary physician, she was prescribed her 10mg of *Citalopram* for depression, and recommended that she seek counseling. A summary of the clinical interview revealed:

Client Presentation (Individual)

Upon meeting Kim, she appeared well groomed. Kim admitted that she was nervous but glad she followed through with her doctor's recommendation that she contact a counselor. Initially her posture appeared tense, as she hung onto her purse for the first half of our hour interview. Throughout our initial meeting, Kim was cooperative; our conversation flowed naturally with a few intermittent periods of brief silence as she gathered her thoughts. Kim was fully orientated and did not present any behaviors that would indicate acute trauma or shock.

Assessments given included a clinical interview with particular attention given to psychosocial history, family history, and depression check list. Identified strengths include:

- Stable work history
- Positive support network
- Motivated for change
- Integrated moral values
- Accepts guidance/feedback

Based on information provided in Kim's initial clinical interview and information gleaned from her completed assessments and prior research, the following treatment plan was devised.

Presenting Problems:

A. Primary: Childhood trauma – sexual abuse
B. Secondary: Generalized anxiety and depression, partner relational conflict, suicidal ideation

Treatment Plan:

1. Resolve conflicting feelings that are associated with childhood trauma.
2. Develop an awareness of how childhood trauma is affecting current functioning.
3. Learn how childhood trauma resulted in interpersonal problems.
4. Learn to forgive perpetrators and turn them over to God.
5. Resolve past childhood/family issues, leading to less fear, anger, depression, and to a greater sense of confidence and self-esteem.

Short-Term Objectives/Therapeutic Intervention

1. Describe the traumatic experiences that were endured as a child and the feelings of helplessness, rage, hurt, and sadness that resulted from these experiences.
2. Verbalize powerlessness and unmanageability due to the traumatic experience.
3. Identify the unhealthy rules and roles learned in the family of origin.
4. Verbalize an understanding of how childhood abuse led to emotional and social problems.
5. Disclose to spouse the traumatic child abuse experience.

6. List and replace the dysfunctional thoughts, feelings, and behaviors learned during childhood trauma.
7. List five ways God can assist in recovery.
8. Verbalize an understanding of the power of forgiving the perpetrator.
9. Write a letter to the perpetrator, detailing the childhood abuse and its effect on one's thoughts, feelings, and behavior.

Counseling Sessions (Individual)

Kim agreed to engage in counseling, and contracted to meet weekly. Initial sessions were focused on clarifying Kim's issues and identifying potential challenges. These problems became target goals and milestones to gauge success. Emotional roadblocks for Kim included misplaced shame and blame, blaming others, blaming God, and unforgiveness. The following is a narrative with generalized subject headings of Kim's sessions.

Misplaced Shame and Blame

The origin of this tragically false image is understandable, and Kim's case is no different. One of the great traumas of sexual abuse is that the innocent are made to feel partners in their abuse. If the abuse occurred during one's childhood, the pressures are magnified even more. Since Kim was a child, and her molester was her uncle, his lies about what was transpiring were considered authoritative.

Her uncle cruelly manipulated Kim's emotions by heaping shame and blame upon her until her tender conscience was shattered by an overwhelming burden of false guilt. Her abuser insisted upon secrecy and told her she deserved what has happening to her because she was a bad girl. This only inflamed her conviction that something shameful was wrong with her.

Kim once held great respect for her uncle. Using as much empathy as I could, I validated that it would be unthinkable that such a person could do something like this, especially to an eight-year-old. I recognized that she was forced into an intolerable dilemma and that it is not surprising that many victims opt to blame themselves rather than their abuser. As Kim began to share more of her story, a pattern of self-blame began to become prevalent. Kim seemed imprisoned by a guilt-ridden cycle of self-loathing that simply got harder and harder to break out of as the years progressed.

Blaming Others

Rationally we agree the offender is exceptionally blameworthy; in Kim's case, her uncle should be the obvious target of her anger and blame. Other possibilities in situations of abuse are that it would seem normal that victims would blame those who should have provided better protection. However, in Kim's case, she heaped her anger on her friends and others.

It became apparent that blaming people, particularly her mother, was an attractive option, because blaming them seemed like the only way to help relieve the crushing weight of false guilt. Kim also blamed her employer or friends for her irritable moods and source of her resentment. Kim knew that facing her uncle and revealing her secret to her family would be too difficult, so she avoided direct confrontation, thus resorting to blaming others for her interpersonal problems. However, this only fueled resentment and bitterness that continually impaired Kim's ability to find healing and forgiveness.

Kim admitted that her desire to see others suffer was particularly addictive. Like a junkie, Kim focused on the temporary relief that blaming others provided. However, Kim slowly began to realize that her actions were an attempt to satisfy her lust for revenge. Kim was infuriated at the thought of forgiving her uncle. After establishing rapport, I began to gently inform Kim that forgiveness carries no hint that the offense does not matter, nor it is minor, nor is the victim is to blame. On the contrary, to forgive is to acknowledge that the offender is at fault. If it were not the offender's fault, or he or she could not help it, or the offence were somehow excusable, there could be no forgiveness because there would be nothing to forgive. For as long as we are dominated by the longing to see someone suffer, that person has succeeded in dragging us down to his or her despicable level.

As therapy progressed, Kim began to show signs that she understood that regardless of how it manifests itself, resentment and unforgiveness enslave and corrupt victims. Bitter people are beautiful people turned ugly. The process is reversible, once we discover the liberating power of letting go of resentment.

We move from victim to victor only when we break free from resentment's death grip. Yet the offender's actions cannot be swept under the carpet. What the offender did was blameworthy and deserving of the severest punishment. What Kim suffered must be avenged, and yet the irony is that seeking revenge keeps the victim from healing. This dilemma must be resolved, but how? This is what Kim wanted to discover in counseling.

Blaming God

Blaming God was a complicated but important issue as Kim's sessions unfolded. Again, this option brought a degree of comfort for Kim, because blaming God seemed justified. Though Kim attended Mass regularly, she held a quiet resentment toward God, whom she blamed for what happened to her. To help illustrate how she was feeling, the following story was shared and discussed.

A doctor is particularly fond of a little patient of his. All that the little child can focus on, however, is the vaccinations the doctor gave her and the painful stitches in her cuts. To her childish mind, the doctor is not a healer but a torturer. One day the child is strolling along the sidewalk when suddenly she sees the doctor approaching. In her panic she flees across the road and is hit by a car, breaking her leg. Of course, the first on the scene is that dreaded doctor.

In time, her physical pain is overshadowed by the shame of walking with a severe limp. It scars her whole life, making her unpopular at school, later interfering with her marriage prospects, her career opportunities, her self-image, and countless other aspects of her life. All of this inflames her hate for doctors. She spends her life avoiding them and so never discovers that simple surgery would have cured her limp.

Moral of the story: Like that little child, a misunderstanding causes far too many survivors of sexual abuse to waste their lives resenting and avoiding God. What makes resentment against God so tragic is that if there truly is a caring, supernatural God, then he, like no therapist in the world, would understand and feel one's pain and be able to bring healing. The God one thought one hated is not real. The real God, as contrasted with the uncaring God one's imagination might have created, is tender,

compassionate, and understanding. This is not an easy concept to grasp, living as we do in a world that is violently opposed to his ways of love and justice.

Slowly Kim began to realize blaming God kept her from the one Person who fully understands her anguish. Kim was encouraged to seek God, who offers perfect comfort and is able to bring supernatural healing. Kim made significant progress in reconciling her relationship with God and began verbalizing her understanding that harboring resentment toward God is ultimately as self-destructive as suicide, and as counterproductive as a drowning person fighting off a rescuer. After talking with her priest, Kim began to understand that hating herself is also a dead end, and hating others keeps one in pain.

Conclusion and Summary (Individual)

After 10 weeks of intense counseling, Kim has responded well to counseling. She has reported a significant improvement in her mood and will consult with her physician to discuss discontinuing her prescription for her medication regimen for depression. Throughout the therapeutic process, Kim's mood was evaluated for continued suicide ideation. Kim consistently reported that she was free of such thoughts at the time.

Kim had transcribed a letter to her uncle. However, she feels she is not ready to confront her uncle and is uncertain that she should mail the letter to him. At the conclusion of individual therapy, Kim's husband was invited to attend her counseling session, and during this session Kim was able to share with Alonto her secret of childhood sexual abuse. Kim's revelation created an emotional exchange with Alonto.

During this meeting, Kim also talked to her husband about marriage counseling in hopes of improving their marital relationship, in hopes that together, she will be able to continue on the path of healing. Alonto, who had remained supportive thus far, agreed. They agreed to attend counseling together before they plan a trip to the Philippines to discuss with her parents her childhood experience. Also, Kim was able to share with Alonto a letter she wrote to her perpetrator detailing her feelings and her offer of forgiveness.

At the conclusion of individual counseling, I recommended that Kim consult her doctor regarding her medication. After being provided a summary of her progress, her doctor discontinued her medication regimen for depression. Kim was also given a referral to the Physical Abuse Centre, where she joined the support group for sexual abuse survivors.

Alonto and Kim recognize their marital problems revolve around arguing and a lack of interest in one another. They also recognize the significant impact Kim's secret has had on their relationship. With the secret now out, the dynamics in their marriage and their relationship to their children and family have changed. The Smiths complain that they rarely go out anymore and have sought counseling because they feel they are growing apart and the reaction from their family was not what they expected.

Marital Counseling

At our first meeting, Kim and Alonto discussed their expectations about what they want to get out of therapy and what their goals are in terms of the relationship.

Two separate appointments were scheduled for the completion of their Taylor-Johnson and Marriage Awareness Inventory (a relationship screening tool developed by this author). At their second meeting, some their specific complaints and goals were clarified. Homework was also discussed, and a counseling contract was signed. Alonto and Kim agreed to go to a movie and dinner monthly. They also agreed to set aside one night per week for intimacy that may or may not result in intercourse. With time together, it is expected that this couple, who have been married for about a three decades, will be able to renew their love and desire for one another. Additionally, it was agreed that Alonto will attend the Physical Abuse Centre and speak with one of their counselors to become better informed about the issues and challenges that adult survivors of molestation endure, and how spouses of survivors can engage in the healing process.

Clinical Assessments & Interview

In order to measure how the treatment is proceeding, the Smiths' treatment plan required weekly counseling sessions, with individual sessions scheduled as needed. The Smiths were also required to keep a detailed recording of their date nights and when they do make love. The chart would be evaluated once per month during one of their weekly sessions with their counselor. Their major arguments would also be recorded and discussed on a weekly basis. Therapy would continue until the couple is satisfied that they are getting along well enough so that frequent fighting does not erupt. This means that the couple should not have more than one "fight" per week. Of course, couples will discuss things and argue, so definitions as to

what behaviors are acceptable must be developed at the beginning of treatment. Learning how to fight fair should also be a part of the equation. The first three sessions were geared toward completing a battery of assessments. Time was also given for discussion of their perception of current problems.

In contemplating the Smith family system and the information Kim and Alonto provided, it was observed that patterns of interaction between them seem to be flawed regarding their constant talking over each other and their inability to actively listen. Furthermore, their initial sessions as a couple revealed they each have brought their own problems into the marriage and these issues continue to grow. At this juncture, it is assumed that systemic methods can be used to help Alonto and Kim, particularly when interventions are geared to create major changes in their subsystems. If this is deemed untrue, or when clinical experience does not support this recommendation, clinical interventions will be revised.

A careful intake diagnosis was undertaken to guide the counseling process and to assist in gauging progress and success.

Axis 1 V61.1 Partner Relational Problem
Axis 2 V71.09 No diagnosis
Axis 3 Chronic back pain
Axis 4 Health
Axis 5 Current: 51-60 Prior: 81-90
Stress Severity Rating: Moderate

Treatment Technique: Family therapy

Treatment Approach: Solution-focused, cognitive restructuring, behavioral techniques

Presenting Problems:

Primary: Partner relational conflicts, communication problems, conflict resolution
Secondary: Childhood trauma, family conflicts, parent-child relational problems

Treatment Plan:

Primary Problem: Partner relational conflicts

- Behavioral Definition
- Lacks communication with spouse
- Has a pattern of superficial communication, frequent arguing, infrequent sexual enjoyment, and a feeling of emotional distance from partner
- Poor conflict resolution skills, avoidance

Long-Term Goals

Develop the skills necessary to maintain open, effective communication, sexual intimacy, and enjoyable time with partner.

Short-Term Objectives/Therapeutic Interventions

- Verbalize powerlessness and unmanageability that have resulted from partner relational conflicts.
- Client and partner give their perspective on the nature of and cause for their relational conflicts.
- Complete assessments and questionnaires for assessing partner relational conflicts.

- Verbalize an acceptance of the responsibility for own role in relational problems.
- Identify the positive and negative aspects of the current relationship.
- Discuss the sexual problems that exist in the relationship and demonstrate the ability to show intimacy verbally and nonverbally.
- Implement healthy communication skills.
- Verbalize acceptance of the need for continued therapy to improve the relationship and to maintain gains.
- Utilize conflict resolution skills.
- Increase the quality and frequency of healthy communication with the partner.
- Increase the frequency of pleasurable activities with partner.

Homework to Be Assigned

- Communication skills
- Problem-solving skills
- Forming stable relationships
- Identifying conflict themes
- Is it romance or is it fear?
- Is my anger due to unmet expectations?
- Learning to ask instead of demand

Problems evident in the relationship pertain to communication difficulties as well as individual differences. Goals of couple therapy are to resolve the communication problems, but other, more serious, problems will need to be resolved

outside of the scope of couple therapy with individual counseling sessions. While communication and individual differences are easily treated, they do interfere with the couple's enjoyment of the marriage, and so marital therapy is recommended. However, it is noted that their individual dilemmas do intrude on the process.

The rationale for projecting these goals is that while the therapy may be futile if in fact individual therapy yields surprises, it is still preferable to treat the symptoms – in this case communication difficulties – rather than to ignore them. Furthermore, the communication problems do not appear to be difficult to resolve, particularly if they are able to resolve their anger and disappointment stemming from Kim's disclosure of prior sexual molestation.

The couple has the resources to engage in therapy. However, they do lack time and will have to rearrange their schedules in order to commit to therapy.

Intervention Plan & Analysis

In this particular case, I have chosen to use an integrative dynamic-systems method as outlined in Sperry and Carlson's (2000) article. In addition, the first part of the intervention plan would include behavior marital therapy that is solution-focused. With this particular approach, it is theorized that problems are not inherent in the relationship but within the individuals themselves, so Alonto and Kim have been required to agree to certain behavior goals. With the Smith case, if they can begin to argue less and begin to communicate more effectively, it is hoped they will be able to create space and a sense of harmony; then they will eventually become closer when individual therapy begins.

Alonto and Kim were asked to create a list of problems and potential solutions that will be discussed in therapy. Each had complaints about the other with respect to their marital dynamics and intimacy. Specifically, Alonto is disturbed by the fact that they do not make love very often, and he is confused as to why Kim kept her sexual molestation a secret from him. Kim desires more emotional support and wishes to resume socializing as a couple more frequently. These are typical marital complaints, and many counselors may consider such problems rather benign. However, Kim's prior trauma is significant, and the constant fighting in the Smith relationship is about other, obscure things. These things again may be best handled separately in individual therapy.

Week 3 Summary

Kim and Alonto have similar belief systems in a general sense. Even though Alonto is Catholic, he is not religious and rarely attends Mass. Their children go to a Catholic church on holidays and profess to be Catholic, but there are few rituals employed in their home. Religion is not discussed much. Yet, they both want the same things and have similar political beliefs. They believe in monogamy and marriage but first see themselves as individuals and are ready to separate if the marriage is not conducive to their personal growth. That has always been their ideology regarding marriage. The couple's strength is their similar view of the world and their love for their children. Still, there are many weaknesses, such as their inability to support one another, particularly at this crux in their lives when their children are growing older.

I believe this family has a chance at success, but there are factors that do hinder their growth. First and foremost, Alonto and Kim state that they love each other and are not interested in getting a divorce, and their commitment to counseling shows they are willing to work on their relationship. However, Kim is still dealing with her own issues stemming for childhood sexual abuse, and it is uncertain if Alonto understands how to meet his wife's emotional needs. Another factor is that Alonto may have his own problems that may need to be addressed, and it is hard to tell what will happen in therapy after that occurs. As mentioned earlier, Kim has made significant progress; however, there are still unresolved issues that have affected all of her relationships. It is my opinion that these situations continue to exacerbate their problems, but their existence does not preclude treatment for the basic emotional and communication problems in their relationship.

The family's developmental stage only adds to the stress as they deal with a variety of different needs presented by their young son and their older children. As mentioned earlier, communication patterns are flawed, and that will need to be addressed in marital therapy. Family therapy is a possibility, as the adult children often enter the disagreements between the parents and they will be returning to Bermuda for a brief visit. It is also noted that Alonto has not contacted the Physical Abuse Centre as agreed in our initial meeting. Alonto maintains that he is committed to attending but has been unable to find time in his schedule.

Week 6 Summary

After six sessions, the Smiths were able to complete two intake sessions, two sessions on communication, and two sessions on conflict resolution. Communication seemed the most important and logical starting point for them. Secrets and misunderstanding have taken a toll on their relationship. Our sessions on communication began with the basics components of good communication, including nonverbal communication and active listening, as well discussion on aggressive, passive, and assertive communication.

Theoretically, all relationships are contingent upon communication for social learning and the development of personal mental schema about self and others. Communication can be defined as the passage of information which requires both a transmitter and receptor. Since communication has two distinct poles, the conveyor of information and the receiver of information, perceptions become important part of the creation of concepts and understanding. Thus perception becomes a part of the communication process. What happens between perception and conception is where misunderstanding often occurs, and with the Smiths, this is where their communication problems surface.

Sessions on communication utilized handouts and role play for integration and application of new skills. Each session was based on the information provided and learned in the prior sessions. During the first communication session, we covered the basics of communication, including the definition of communication (verbal/nonverbal), barriers to communication, and understanding communication in relationships. Alonto and Kim were asked to practice asking themselves four mental

questions before giving a reply to each other when communicating. Those questions were:

- How am I feeling right now?
- What does my partner feel or want?
- Why today, not yesterday? What's different?
- What is the best way for me to respond?

Role play with real problems that have recently come up in their relationship, where poor communication resulted in arguments and unresolved conflict, were used to reinforce and illustrate how good communication skills can produce positive results in their relationship.

The second communication session focused on listening skills, with more role play exercises. The focal point of this session was to identify the key elements of effective listening and learning to listen to understand, rather than listening to respond. To assist with reinforcement and familiarity, the following exercise was used.

Communication Exercise

Alonto: Start talking about a recent problem you would like to share in four or five sentences.

Kim: When Alonto stops talking, repeat back to them what you <u>thought</u> you heard, using some of the phrases below:

I want to be sure I understand what you are saying. It sounds like . . . (your interpretation of what he said)

Is part of what you are saying . . . (your interpretation of what he said)?

What I hear you saying, if I understand you correctly is . . .(your interpretation of what he said)

I want to make sure I am hearing what you are saying . . . (your interpretation of what he said)

What I heard was . . . (your interpretation of what he said. Was that accurate?) Then, reverse the roles, and the second person speaks for 4 or 5 sentences. Then the first person asks perception checking questions.

At the conclusion of each session, as indicated in their treatment plan, Alonto and Kim were required to complete a prescribed homework assignment (see Appendix A). Upon returning to their next counseling session, a few minutes were dedicated to discussing their homework assignment and assessing and dealing with their failure to complete their work if it occurred.

Sessions three and four were designed to assist Alonto and Kim in gaining insight into how their self-perceptions can easily lead to miscommunication. As we gather perceptions, we become interested in those that are similar, and those that are dissimilar are ignored. We begin to identify patterns of perceptions and to develop them into conceptual categories. These categories then mature into ideologies or beliefs. At this level, we begin to perceive through a biased frame of reference: those perceptions that do not fit into our beliefs are ignored when we engage in communication. Our patterns or beliefs often become so rigid that even our

perception of what others are saying is skewed. It is this distortion that becomes the construct paradigm of communication. Miscommunication is then the inability of the person to see another point of view or to translate communication only within the context of their own way of perceiving.

Sessions five and six focused on conflict resolution. The first module sought to normalize conflict by understanding that marriage is the blending of two distinctly different individuals with different backgrounds, values, and personalities – this is why the potential for conflict exists in marriage. Every married couple will have disagreements, but the key to successful relationships is knowing how to resolve conflict. If partners avoid conflict or decide to keep the peace at any price, they will hurt their marriage in the long run.

During these sessions, we utilized their genogram and ecomap to identify patterns of interaction regarding conflict resolution that have surfaced in their relationship and common sources of conflict in their relationship. We also discussed the common methods of conflict resolution in the following handout:

Fight to Win: The "I win, you lose, because I'm right and you're wrong" position usually reflects domination. The relationship is valued less than triumph.

Withdraw: The "I'm uncomfortable, so I'll pull away" position is usually in response to the Fight to Win.

Yield: The "rather than start another argument, whatever you wish is fine" position usually comes about because of poor communication where one person is not heard or valued.

Loving Confrontation: The "I care enough about our relationship to deal with issues lovingly" position places value on the individual and the relationship.

The sixth session focused on role play exercises on handling conflict and expressing forgiveness using a fictional case study followed by another homework assignment. The following exercise was used along with the accompanying mini case study to illustrate the importance of conflict resolution and raise Alonto and Kim's awareness to the areas where they can improve regarding their pattern of relating.

How to Handle Conflict

Make sure you clarify what it is you are discussing.

If either of you is too angry to discuss the situation or problem, then set a time to get together later to discuss it.

Be flexible and open to other solutions than your own. Willingness to compromise is important.

Don't push one another's buttons. Don't be sarcastic or attack one another's self-image.

Don't interrupt one another. Listen. (Be aware of your own body language and what it may be saying.)

Talk in a calm, respectful voice. Ranting and raving accomplishes nothing.

Remember that a fair argument can enhance a marriage. Fight for your marriage, not to win.

Case Study

Charlie and Beth have come to you for help. They have been married for five years. You are relieved to hear that they have been faithful to each other, but you wonder how their resentment toward each other has grown. They express the core of the frustrations.

Beth: Charlie makes me feel so unlovable and unappreciated. He always has to be right. The things he has said to me when he's angry, the way he treats me around the kids, his arrogant ways in front of my in laws – I just can't let him get by with this. Why should I forgive him? He made his bed, let him lie in it!

Charlie: If I've hurt her, then she deserves it. I work hard all day to put a roof over her head and the children, and all I hear is griping. I can never do enough, never say things just right, and never be kind enough to her folks. She's done more than her share to make me miserable. I'm only balancing the scales!

Discussion Question: If Charlie and Beth don't change, what do you see happening in their relationship? How would you counsel them? In addition to forgiving one another, what else do Charlie and Beth need to do?

The conflict resolution sessions focused on reconstructing Alonto's and Kim's thought patterns on conflict and teaching peacemaking skills through interactive role play, followed by homework for application. Conflict resolution is based on the understanding that conflict exists whenever incompatible activities or expectations occur (Deutsch, 1973). Interpersonal conflict exists when the actions of one person trying to achieve goals prevent, block, or interfere with another person's attempt to achieve goals (Johnson & Johnson, 1995). Alonto and Kim have begun to learn that

whenever conflict occurs, it can be managed constructively, thus enhancing mutual problem solving and maximizing joint outcomes while preserving mutual respect and trust. However, if conflict is poorly managed, it can be destructive; creating anger, resentment, hurt feelings, and distrust.

As of late, Alonto and Kim have responded well to their hour-long weekly sessions. As a result, they are learning the skills they need to regulate their behavior and deal with adversity rather than avoid conflict or argue. They report a decline in the frequency and intensity of their arguments, preferring to utilize their skills or to bring unresolved problems to therapy. Furthermore, Alonto has attended the Physical Abuse Centre and is gaining insight into the issues and problems that survivors of molestation endure and the effect on spouses of survivors.

Week 7 (Home Visit)

A home visit has been scheduled to meet the adult children, who have returned to Bermuda for vacation. It is hoped that this meeting will yield valuable information, assist Alonto and Kim with revitalizing their relationship, and allow the adult children to express their feelings. Upon my arrival, I was greeted by Kim, who invited me to the living room, where I was introduced to Analyn, Catherine, and Jayson. Their reception was friendly and warm. After exchanging pleasantries, Jayson returned to his room. After a brief explanation of my visit and clarification of goals and outcomes, we proceeded with our family meeting. The following narrative contains a synopsis of the discussion.

Catherine – Catherine was the first to speak and was the most vocal throughout our discussion. Catherine was supportive of her mother and was concerned about her well-being. More importantly, Catherine expressed anger toward her great-uncle, stating, "He needs to go to prison."

Kim – Kim seemed to understand Catherine's anger but was reluctant to commit to pursuing legal action against her uncle. Kim stated, "I've forgiven him. I just want to move on."

Alonto – Alonto sought to remind his children of the purpose of the meeting by stating, "We are here to learn how we can support your mom and each other." It seemed Alonto was the only person who was able to discuss the issues dispassionately.

Analyn – Analyn was more concerned about the family meeting planned with her grandparents, uncle, and aunts, stating, "When is the meeting planned, and do we all have to attend?"

Catherine – Catherine interpreted Analyn questions as an indication that she was not planning on attending, stating, "Why aren't you coming? This is important!"

Analyn – Analyn replied, "I know it's important – that's why I'm here. I just don't see why all of us have go?"

Alonto – Alonto interjected, "We are not sure if we'll have the meeting, your mom is having reservations about going, your grandmother spoke to your uncle, and he denied the whole thing."

Catherine – Catherine replied, "I don't care, he's a pervert!"

Kim – Kim interjected, "This is not why I asked you all here. I love you both, and your father and I are going to counseling, and we need your support."

The home visit lasted about an hour and produced valuable information about their family dynamics. After allowing the family to freely discuss their issues, with intermittent prompting with Kim's prior permission, a chronology of Kim's individual counseling and the subsequent marital counseling was shared with the family. It was important to share with the family information that will assist them in improving their family relationships. It was hoped that despite traumatic experiences, unexpected events, difficult relationships, and outside influences that threaten their family and harm that has occurred, families can overcome, and that restoring stability is not the responsibility of one person or a couple. It requires the entire family to participate.

The balance of the home visit focused on facilitating a conversation between all four members about past hurts, misunderstandings, and expectations, both current and future. The conversation between each family member was balanced and often emotional. Analyn thought her parents favored Catherine but came to realize that her mother's overprotection during her childhood and adolescent years was a response to her mother's fear that someone might victimize her. Alonto and Kim shared their regret concerning their decision to allow Analyn to stay behind in the Philippines to finish school, because they concluded that the separation somehow contributed to Analyn's feelings. Catherine admitted that she admired Analyn and was somewhat jealous of her, and complimented Analyn on how strong she was. Alonto and Kim

apologized and asked for forgiveness from one another, Alonto for being insensitive to Kim's needs; and Kim for not sharing the truth with Alonto about her childhood trauma sooner. During the last few minutes, Jayson was invited to participate. He was very excited to have his sister's home and his humor and playful demeanor was a welcome reprieve from an emotional exchange.

Week 8 (Alonto, Individual)

During Alonto's individual session, he talked freely about his struggles and progress made over the past few weeks. In particular, Alonto continues to struggle with understanding why Kim kept her secret from him. Though Alonto loves Kim, knowledge of her secret angered him. Alonto felt that Kim's failure to tell him about her prior molestation was a form of betrayal, and because of this he feels conflicted. On the one hand, Alonto is angered that Kim did not trust him with her secret earlier. (Alonto also intimated that he suspected that something was wrong, but he was not sure what it was.) On the other hand, Alonto deeply loves Kim. Alonto is also disappointed with his selfish attitude, particularly when Kim needed him most. Additionally, Alonto shared feelings of fear and guilt regarding his attitude toward Kim regarding the frequency of their sexual intimacy, and he is wondering if his behavior and attitude have made things worse for Kim. When asked if their sexual intimacy has increased in frequency, he said, "No, but we have been talking more and doing things together, and it feels good."

Alonto said the home visit was a big help, and he feels that their relationship with Kim has improved. Though he had reservations about what would transpire, he

was glad his daughters were able share their feelings. Alonto also mentioned he has one more meeting with the counselor at the Physical Abuse Centre and that he was glad he was required him to attend; though these past few weeks have required him to make huge sacrifices regarding his time at work, between counseling and the Physical Abuse Centre he has learned so much. The reality of Kim's trauma is starting to set in, as now Alonto is aware that Kim may struggle with sexual intimacy for years. Alonto is also aware that our sessions are nearing an end, and he is hoping I can help them decide on whether or not they should fly to the Philippines for their family meeting.

Week 9 (Kim, Individual)

During Kim's individual session, she wanted to discuss her trip to the Philippines. She has spoken to her mother only twice since her mother's betrayal. Since her confrontation with Kim's uncle, the entire family in the Philippines has taken sides. What was supposed to be a carefully planned intervention has now been ruined, so Kim is wondering if her original plan is worth the effort and expense. Rather than offering Kim my opinion, I allowed her to talk through her dilemma by looking at the cost and benefits of either decision. I encouraged Kim to seek the Lord in prayer and to avoid making a unilateral decision without her husband's agreement. Furthermore, her decision should be weighed against what she feels will keep her on the path of healing.

Kim is finding the support group helpful and is expressing a desire to volunteer after her counseling sessions end. Kim reported that she had an extended conversation

with Alonto after our home visit about everything that has transpired. Though things have improved, she finds herself unwilling to initiate sexual intimacy. Kim appreciates the space Alonto has given her, and though his attitude has changed, she is worried that she has disappointed him, even though he has told her that he is happy. Figuring that Kim's situation maybe aggravated hormonal changes, I suggested she talk to her doctor about menopause.

Week 10

Session ten was focused on forgiveness. This particular module imported biblical principles that Alonto and Kim espoused, with the added benefit of the counselor to facilitate the process. Like previous sessions, this session utilized handouts and practical application using current unresolved issues that have arisen in therapy.

The session began by asking Alonto and Kim to discuss their answers to the following two questions:

What would you say it means to forgive another person?

Why is it often so difficult to request forgiveness or grant forgiveness in relationships?

Then, together we discussed the following definitions of forgiveness for further clarification:

In the Bible it says that they asked Jesus how many times you should forgive, and he said 70 times 7. Well, I want you all to know that I'm keeping count. – Hillary Clinton

Forgiveness if freeing up and putting to better use the energy once consumed by holding grudges, harboring resentments, and nursing unhealed wounds. It is

rediscovering the strengths we always had and reallocating our limitless capacity to understand and accept other people and ourselves. – Author Unknown

I learned that forgiveness is not just sweeping things under the mat. Rather, it is facing those persons or situations head on, and after looking at the problem for what it is, forgiving the person or persons who have wronged you. – Rev. Alfred Cockfield

Following this exercise, we spent the balance of the session discussing the steps to forgiveness (see Appendix B). Alonto and Kim were required to write the answers to each question or example. As we discussed the relevance each point had on their current situation, the session culminated with asking Alonto and Kim to mutually express and request forgiveness from one another. Though they had expressed forgiveness to each other during the home visit, it seemed important guide them through the steps of forgiveness from confronting their emotional pain through deciding to forgive. This process aims to eliminate false perceptions and false pretences regarding forgiveness.

Kim and Alonto decided to forgive one another. Kim sought forgiveness for not sharing with Alonto the truth about her molestation, and Alonto asked for forgiveness for his insensitivity and confessed his feelings of anger and confusion. This particular session exceeded 90 minutes, which was expected. Additional time was needed to discuss steps towards intimacy and discharge from service. An additional session was scheduled to evaluate their success, and to discuss further recommendations.

Discharge Summary

Alonto and Kim have completed ten weeks of counseling over a four-month period. These sessions included marital counseling, individual counseling, and family counseling. At the onset of counseling, Alonto and Kim rated their relationship as "moderate" on the Couples Relationship Inventory, and at discharge their view of the relationship has been upgraded to "good." Most of the short-term objectives and therapeutic interventions were completed, as well as the assigned homework. With improved relational skills and a renewed commitment to their relationship, Alonto and Kim have expressed their future in positive terms.

Though Alonto and Kim have expressed an interest in continuing with family counseling due to a major disagreement that has recently erupted between their daughters regarding the proposed family trip to the Philippines, there seems to be little significant clinical evidence to support continuation. Though the current rift between the two siblings is unfortunate, the relational connectivity between them and their immediate family remains strong. Therefore, the following recommendations are being offered to assist the Smith family:

1. Kim to continue to participate in sexual abuse survivor support group
2. Alonto to utilize EAP services through his employer as needed
3. Alonto and Kim to attend a marriage retreat within the next twelve months
4. Alonto and Kim to connect with Jayson's school counselor regarding any potential issues that may arise
5. Alonto and Kim to read *Building Strong Families* by Dennis Rainey (2002)

Concluding Thoughts & Reflections

Relationships can be difficult, and marriages break up today far too frequently. The Smith case study illustrates that couples can mend broken relationships with the help of therapy. Talking with a trained counselor can help families understand and resolve their underlying emotional distress in their relationship. The Smith case helped in identifying the benefit of setting clinical goals. Goals helped the Smiths see past their problems, thus allowing them to envision the relationship they desired. By identifying solutions to their relationship issues, the Smiths were able to move beyond the barriers that were blocking them from having the life and relationship they wanted. The Smith case helped to solidify my conviction that if we face our difficulties constructively and confidently, it can free us to enjoy all the good things life has to offer.

Couples therapy allows people to address problems in their relationships so that their union can continue in a successful manner. In evaluating the case study above, problems in the Smith family are obvious. The Smiths had several dilemmas, including childhood sexual abuse, communication, conflict resolution, intimacy issues, and a sense of not connecting with one another. While no therapy is perfect, the therapy suggested for them included a combination approach where couple and individual therapies were utilized.

Though language was not an issue in this case, sensitivity to cultural nuances was important. When contacted initially by Kim, and being made aware of her cultural ethnicity, I was strongly considering referring the case. As counselor, I needed to be sure that I could be sensitive to the unique cultural issues of her family

system and to my own prejudices, beliefs, and attitudes, and if I felt I was unable to bridge the cultural divide and prevent my cultural mores from negatively infiltrating the therapeutic process, I would have refused the case. This case helped solidify the importance of cultural understanding and sensitivity. I have come to believe it is impossible to understand fully a family and its problems, communicate with it meaningfully, secure its cooperation and really help it, unless the therapist possesses intimate knowledge of the family culturally.

The Smith case also illustrated the importance of clinical supervision. The clinical supervision provided in this case helped with skill development and the emotional/interpersonal dynamics of self-discovery. Looking back on the supervision process, the experience was somewhat of a rite of passage, where clinical skills were refined and theory and practice were integrated. Supervision helped insulate me from burnout, boosted self-confidence, helped the emergence of my unique professional identity, and was preparatory for my pending induction into the counseling profession.

Without the benefit of initial clinical assessments, vital information about the Smith family would been have missing, and the absence of this information would have severely hindered the understanding of the problems facing the marital dyad and relational interaction within the family system. Combining clinical interviews with standardized clinical assessments, therapists are then able to map and interpret the gathered information for the creation of theories and the formulation of treatment plans. The Smith case showed to there is no substitute for careful and deliberate assessments prior to beginning therapeutic interventions.

This case also required extensive reading and research regarding childhood sexual molestation. Without this information, it would have been impossible to understand the primary source of Kim's depression and the subsequent impact that reverberated throughout her family. As important as this information was in understanding the Smith family, the integration of biblical theology provided the canvas and model for success. Furthermore, the Smith case provided an opportunity to blend principles from systems theory, structured therapy, cognitive-behavior therapy, and solution-focused counseling.

Appendix A

Permission to Record

New Life Church of Nazarene
The Center for Relationship & Family Counseling

Permission to Record

Privacy Statement

Written assessments and recorded sessions are stored digitally, and are erased after they are downloaded and reviewed by your counselor. These files will not be copied or shared with any third party without your written permission.

Purpose Statement

The purpose of recording these sessions is for the creation of a case study to be used in a Thesis Project. I understand that appropriate measures will be taken to disguise my identity, including names, dates, and events. This consent covers by individual and family counseling.

I hereby give permission to TCRFC to record my counseling sessions for use as a case study for Rev. Ernest Peets Thesis project.

Case No. 0607—

Client: [signature] Date: March 3, 2007

Counselor: [signature] Date: 3/3/07

Appendix B

Initial Therapy Intake Form

Initial Therapy Intake Form

Name [redacted] Age 49 D.O.B. [redacted]

Address [redacted]

Parish [redacted] Zip [redacted]

Home Phone [redacted] Work Phone [redacted]

Cell Phone: _____ E-mail _____

Occupation Care Taker Employer [redacted]

Marital Status Married Name of Spouse/Partner _____

How Long Have Both of You Been Together? 25yrs Religion Catholic

Do you have children? [✓] Yes [ ] No Ages: 23 (G) 21 (G) 10 (B) → Adopted

There are times when prior medical and psychological records maybe requested.

Please make sure that all information given below is correct.

Do You Smoke? NO How Much? _____

Do You Drink? NO How Much? _____

Are you on medication? ✓ If yes, what kind? Depression

How often? Once A Day

Any Previous Therapy/Counseling? NO If Yes, Describe: _____

When and Number of Sessions: N/A

Type of Therapy/Counseling: N/A

How were you referred: [redacted]

Briefly describe the reason why you are now seeking counseling service, and how we can help:

I've been depressed and angry. I cry every day and I feel like a failure. I told my boss I was molested and I think I am Dirty. My husband loves me but we have problems with sex and talking

What do you wish to achieve with counseling?

I want to feel better, be a better wife and get alons with my family

What problems are occurring in your life or your relationships?

I feel bad about myself and I don't want to sleep with my husband. I'm angry every day.

What would success look like for you?

my husband and I would be happy

Appendix C

Depression Self-Check

Wife - Intake

Depression Self-Check

Name: [redacted] **DATE:** [redacted]

1. **Sadness:** Have you been feeling sad or down in the dumps?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
2. **Discouragement:** Does the future look hopeless?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
3. **Low self-esteem:** Do you feel worthless or think of yourself as a failure?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
4. **Inferiority:** Do you feel inadequate or inferior to others?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
5. **Guilt:** Do you get self-critical and blame yourself for everything?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot

6. **Indecisiveness:** Do you have trouble making up your mind about things?
   - ○ Not at all
   - ✓ Somewhat
   - ○ Moderately
   - ○ A lot
7. **Irritability and frustration:** Have you been feeling resentful and angry a good deal of the time?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
8. ***Loss of interest in life:*** *Have you lost interest in your career, your hobbies, your* family, or your friends?
   - ○ Not at all
   - ○ Somewhat
   - ○ Moderately
   - ✓ A lot
9. **Loss of motivation:** Do you feel overwhelmed and have to push yourself hard to do things?
   - ○ Not at all
   - ○ Somewhat
   - ✓ Moderately
   - ○ A lot
10. **Poor self-image:** Do you think you're looking old or unattractive?
    - ○ Not at all
    - ○ Somewhat
    - ○ Moderately
    - ✓ A lot

Appendix D

Relationship Awareness Inventory

Wife - Inventory

Name: [redacted] **Date:** [redacted]

Relationship Awareness Inventory

A Relationship Inventory is not a test you pass or fail – it is a survey of your opinions and perceptions. An inventory of your relationship will help your counselor develop a counseling program to suit your needs. Try to answer these questions as honestly as you can.

Communication

1. How would you rate your communication between you and your partner?

A. We have good communication
B. Needs improvement
C. We have some problems
(D) Our communication is poor

2. My partner is?

A. A better listener than a talker
B. A better talker than a listener
(C) Needs improvement in both areas

3. When communicating with your partner, do you feel understood?

A. Yes, all the time
B. Most of the time
C. Some of the time
(D) Hardly at all

4. Who tends to control the conversations?

(A) I do
(B) My partner
C. We equally share in the conversation

5. My partner readily shares his/her feelings with me.

A. Agree
(B) Disagree
C. Not sure

6. I have noticed a decline in our intimacy?

(A) Yes
B. No
C. Not sure

7. I am satisfied with the level of intimacy in our relationship.

A. Yes
B. No
(C) It could be better

8. My partner understands my emotional needs as they relate to intimacy?

A. Yes
(B) No
C. Not sure

Problem Solving

1. When we disagree, we usually?

A. Try to talk things out
(B) Start arguing
C. One of us will give in
D. We normally resolve the problem

2. Rate your opinion of teamwork in your relationship.

A. 0 – 3
B. 4 – 7
(C) 7 – 9
D. 10 – Perfect teamwork

3. Do you feel as a couple you are going in the same direction concerning your goals and desires?

A. Yes
(B) No
C. Not sure

4. I feel my partner is supportive emotionally when we struggle with problems in our relationship.

A. Agree
(B) Disagree
C. Sometimes
D. Not sure

1) I feel safe and secure with my partner.

___True ✓False

2) I can tell my partner my deepest and most private thoughts.

___True ✓False

3) I can trust my partner.

✓True ___False

4) My partner does special things for me.

✓True ___False

5) We make up quickly after fighting.

✓True ___False

6) I hold grudges. I don t tell my partner when I am angry, upset or annoyed.

___True ✓False

7) I feel left out; my partner puts the feelings of my children, parents or friends first.

___True ✓False

8) My partner never backs me up.

___True ✓False

9) My partner and I have different values.

✓ True ___ False

10) My partner embarrasses me in public.

___ True ✓ False

11) My partner and I have different sex drives; I am often frustrated and unhappy.

✓ True ___ False

12) My partner and I often disagree on finances.

___ True ✓ False

13) My partner and I often disagree about parenting our children.

✓ True ___ False

14) My partner never holds or cuddles me.

✓ True ___ False

15) My partner does not listen to me or understand how I feel.

✓ True ___ False

16) My partner talks about and shares his/her day with me.

✓ True ___ False

17) My partner and I spend time alone together.

✓ True ___ False

Based on your answers, you may have identified areas in your relationship that need further discussion. Once these issues have been identified, it is important to figure out how situations that cause you distress can be resolved. Impasses are common and frustrating. Counseling will provide a safe environment for you to talk about these issues safely.

Husband- Inventory

Name: [redacted] **Date:** [redacted]

Relationship Awareness Inventory

A Relationship Inventory is not a test you pass or fail – it is a survey of your opinions and perceptions. An inventory of your relationship will help your counselor develop a counseling program to suit your needs. Try to answer these questions as honestly as you can.

Communication

1. How would you rate your communication between you and your partner?

A. We have good communication
(B.) Needs improvement
C. We have some problems
D. Our communication is poor

2. My partner is?

A. A better listener than a talker
B. A better talker than a listener
(C.) Needs improvement in both areas

3. When communicating with your partner, do you feel understood?

A. Yes, all the time
B. Most of the time
C. Some of the time
(D.) Hardly at all

4. Who tends to control the conversations?

(A.) I do
B. My partner
C. We equally share in the conversation

5. My partner readily shares his/her feelings with me.

A. Agree
(B.) Disagree
C. Not sure

6. I have noticed a decline in our intimacy?

(A.) Yes
B. No
C. Not sure

7. I am satisfied with the level of intimacy in our relationship.

A. Yes
(B.) No
C. It could be better

8. My partner understands my emotional needs as they relate to intimacy?

A. Yes
(B.) No
C. Not sure

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1. When we disagree, we usually?

A. Try to talk things out
B. Start arguing
C. One of us will give in
D. We normally resolve the problem

2. Rate your opinion of teamwork in your relationship.

A. 0 – 3
B. 4 – 7
C. 7 – 9
D. 10 – Perfect teamwork

3. Do you feel as a couple you are going in the same direction concerning your goals and desires?

A. Yes
B. No
C. Not sure

4. I feel my partner is supportive emotionally when we struggle with problems in our relationship.

A. Agree
B. Disagree
C. Sometimes
D. Not sure

1) I feel safe and secure with my partner.

✓True ___False

2) I can tell my partner my deepest and most private thoughts.

✓True ___False

3) I can trust my partner.

✓True ___False

4) My partner does special things for me.

✓True ___False

5) We make up quickly after fighting.

✓True ___False

6) I hold grudges. I don t tell my partner when I am angry, upset or annoyed.

✓True ___False

7) I feel left out; my partner puts the feelings of my children, parents or friends first.

___True ✓False

8) My partner never backs me up.

___True ✓False

✓True ___False

9) My partner and I have different values.

✓True ___False

10) My partner embarrasses me in public.

___True ✓False

11) My partner and I have different sex drives; I am often frustrated and unhappy.

✓True ___False

12) My partner and I often disagree on finances.

___True ✓False

13) My partner and I often disagree about parenting our children.

✓True ___False

14) My partner never holds or cuddles me.

✓True ___False

15) My partner does not listen to me or understand how I feel.

✓True ___False

16) My partner talks about and shares his/her day with me.

17) My partner and I spend time alone together.

✓True ___False

Based on your answers, you may have identified areas in your relationship that need further discussion. Once these issues have been identified, it is important to figure out how situations that cause you distress can be resolved. Impasses are common and frustrating. Counseling will provide a safe environment for you to talk about these issues safely.

Appendix E

Couples Relationship Inventory - Intake

Wife - Intake

Couples Relationship Inventory

Name: [redacted] Date: [redacted]

Rate Your Satisfaction in the following areas from 10% to 100%
Print this document & use the key at the bottom of the page to self-score

1.	Commitment	100 %
2.	Respect for each other	100 %
3.	Intimacy - (sharing, spending time together)	40 %
4.	Fidelity	100 %
5.	Romance	50 %
6.	Fun	70 %
7.	Honesty	40 %
8.	Affection	30 %
9.	Sex	10 %
10.	Money	100 %
11.	Responsibility - (score self and partner and divide by 2)	100 %
12.	Lifestyle Plan	100 %
13.	Fighting Fair - (score self and partner and divide by 2)	100 %
14.	Communication	50 %
15.	Shared Values	100 %
16.	Spirituality	70 %
17.	Parenting	100 %
18.	Anger Management	100 %

Husband-Intake

Couples Relationship Inventory

Name: [redacted] Date: [redacted]

Rate Your Satisfaction in the following areas from 10% to 100%
Print this document & use the key at the bottom of the page to self-score

1.	Commitment	100 %
2.	Respect for each other	100 %
3.	Intimacy - (sharing, spending time together)	40 %
4.	Fidelity	100 %
5.	Romance	60 %
6.	Fun	40 %
7.	Honesty	90 %
8.	Affection	30 %
9.	Sex	30 %
10.	Money	100 %
11.	Responsibility - (score self and partner and divide by 2)	100 %
12.	Lifestyle Plan	90 %
13.	Fighting Fair - (score self and partner and divide by 2)	90 %
14.	Communication	60 %
15.	Shared Values	90 %
16.	Spirituality	50 %
17.	Parenting	85 %
18.	Anger Management	75 %

Intake- Scores

Couples Inventory Score Sheet

Total Scores and Divide by 18

NAME: [redacted] Score: 1360 - Wife

NAME: [redacted] Score: 1330 - Husband

RAW Score of	1440 and over	80-100%	GOOD
RAW Score of	1260 to 1439	70-79.9%	MODERATE
RAW Score of	1080 to 1259	60-69.9%	FAIR (could use therapy)
RAW Score of	900 to 1079	50-59.9%	POOR (E-mail)
RAW Score of	0 to 889	0-49.9%	FAILING (E-mail)

Appendix F

Taylor-Johnson Temperament Analysis

Self

Code PR

TAYLOR–JOHNSON TEMPERAMENT ANALYSIS® PROFILE

Profile Revision of 1984

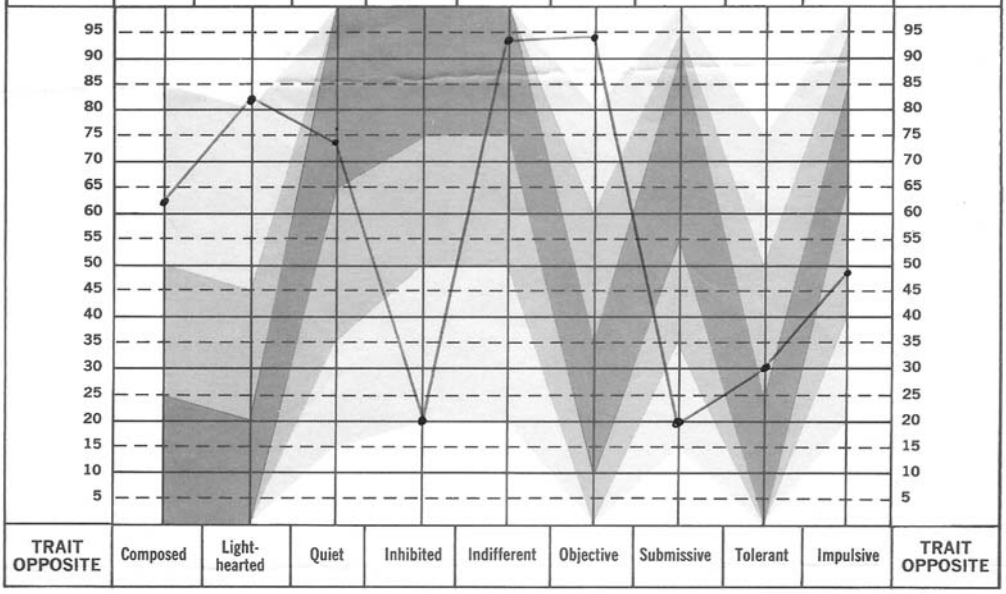
Name [redacted] Age 49 Sex F Date [redacted]

School ____ Grade ____ Degree ____ Major ____ Occupation ____ Counselor EP

Single ____ Years Married ____ Years Divorced ____ Years Widowed ____ Children: M ____ Ages ____ F ____ Ages ____

Answers made by: SELF and/or husband, wife, father, mother, son, daughter, boyfriend, girlfriend or ____ of the person described.

Norm(s):	A	B	C	D	E	F	G	H	I	Attitude (Sten) Score: 4
Mids	0	0	0	0	0	0	0	0	0	Total Mids: 0
Raw score	12	16	34	28	38	22	14	2	28	Raw score
Percentile	62	81	74	20	93	94	20	30	49	Percentile
TRAIT	Nervous	Depressive	Active-Social	Expressive-Responsive	Sympathetic	Subjective	Dominant	Hostile	Self-disciplined	TRAIT



TRAIT OPPOSITE	Composed	Light-hearted	Quiet	Inhibited	Indifferent	Objective	Submissive	Tolerant	Impulsive	TRAIT OPPOSITE

Excellent | Acceptable | Improvement desirable | Improvement needed

DEFINITIONS

TRAITS

Nervous — Tense, high-strung, apprehensive.
Depressive — Pessimistic, discouraged, dejected.
Active-Social — Energetic, enthusiastic, socially involved.
Expressive-Responsive — Spontaneous, affectionate, demonstrative.
Sympathetic — Kind, understanding, compassionate.
Subjective — Emotional, illogical, self-absorbed.
Dominant — Confident, assertive, competitive.
Hostile — Critical, argumentative, punitive.
Self-disciplined — Controlled, methodical, persevering.

OPPOSITES

Composed — Calm, relaxed, tranquil.
Light-hearted — Happy, cheerful, optimistic.
Quiet — Socially inactive, lethargic, withdrawn.
Inhibited — Restrained, unresponsive, repressed.
Indifferent — Unsympathetic, insensitive, unfeeling.
Objective — Fair-minded, reasonable, logical.
Submissive — Passive, compliant, dependent.
Tolerant — Accepting, patient, humane.
Impulsive — Uncontrolled, disorganized, changeable.

Note: Important decisions should not be made on the basis of this profile without confirmation of these results by other means.

Self

Code PR

TAYLOR–JOHNSON TEMPERAMENT ANALYSIS® PROFILE

Profile Revision of 1984

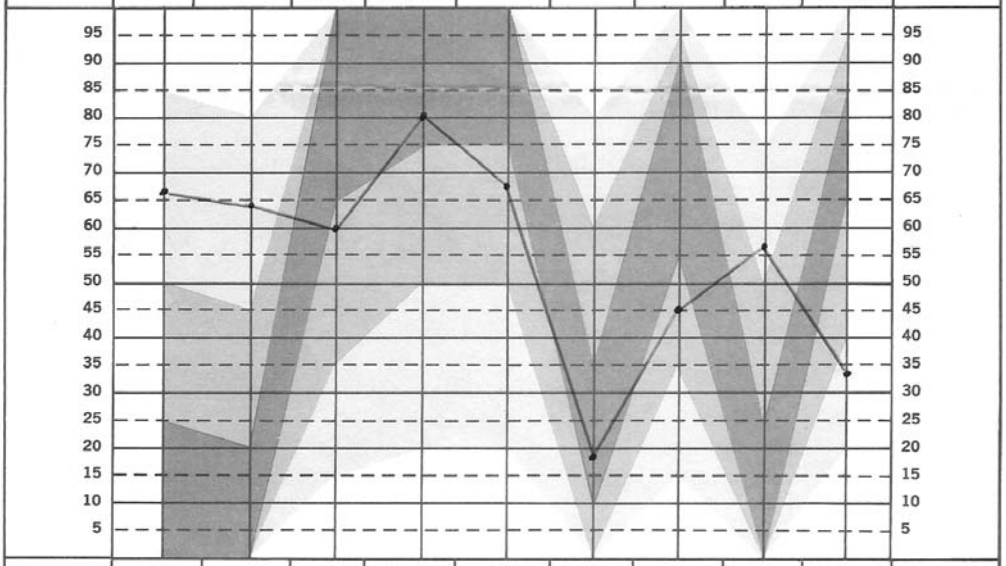
Name [redacted] Age 51 Sex M Date [redacted]

School ____ Grade ____ Degree ____ Major ____ Occupation ____ Counselor EPA

Single ____ Years Married ____ Years Divorced ____ Years Widowed ____ Children: M ____ Ages ____ F ____ Ages ____

Answers made by: (SELF) or husband, wife, father, mother, son, daughter, boyfriend, girlfriend or ____ of the person described.

Norm(s):	A	B	C	D	E	F	G	H	I	Attitude (Stan) Score: 4
Mids	0	0	0	0	0	0	0	0	0	Total Mids: 0
Raw score	10	6	30	36	34	2	24	8	24	Raw score
Percentile	06	04	60	80	67	19	45	57	33	Percentile
TRAIT	Nervous	Depressive	Active-Social	Expressive-Responsive	Sympathetic	Subjective	Dominant	Hostile	Self-disciplined	TRAIT



TRAIT OPPOSITE	Composed	Light-hearted	Quiet	Inhibited	Indifferent	Objective	Submissive	Tolerant	Impulsive	TRAIT OPPOSITE

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Tolerant — Accepting, patient, humane.
Impulsive — Uncontrolled, disorganized, changeable.

Note: Important decisions should not be made on the basis of this profile without confirmation of these results by other means.

Couple: Husband & wife (self)

Code PR

TAYLOR–JOHNSON TEMPERAMENT ANALYSIS® PROFILE

Profile Revision of 1984

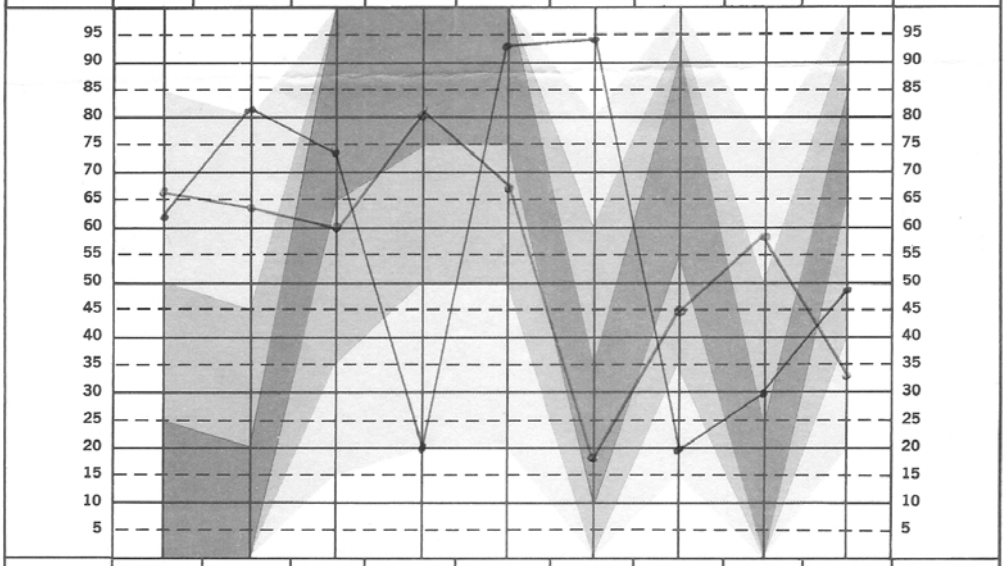
Name [redacted] Age 51/49 Sex Date [redacted]

School Grade Degree Major Occupation Counselor EP

Single Years Married Years Divorced Years Widowed Children: M Ages F Ages

Answers made by: SELF and/or husband, wife, father, mother, son, daughter, boyfriend, girlfriend or of the person described.

Norm(s):	A	B	C	D	E	F	G	H	I	Attitude (Sten) Score: 4 4
Mids										Total Mids:
Raw score	12 10	16 6	34 30	28 36	38 34	22 7	14 24	2 8	28 24	Raw score
Percentile	62 66	81 69	75 60	20 80	93 67	94 19	20 45	30 57	49 33	Percentile
TRAIT	Nervous	Depressive	Active-Social	Expressive-Responsive	Sympathetic	Subjective	Dominant	Hostile	Self-disciplined	TRAIT



TRAIT OPPOSITE	Composed	Light-hearted	Quiet	Inhibited	Indifferent	Objective	Submissive	Tolerant	Impulsive	TRAIT OPPOSITE

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Submissive — Passive, compliant, dependent.
Tolerant — Accepting, patient, humane.
Impulsive — Uncontrolled, disorganized, changeable.

Note: Important decisions should not be made on the basis of this profile without confirmation of these results by other means.

Criss-cross: Wife by Husband

Code PR

TAYLOR–JOHNSON TEMPERAMENT ANALYSIS® PROFILE

Profile Revision of 1984

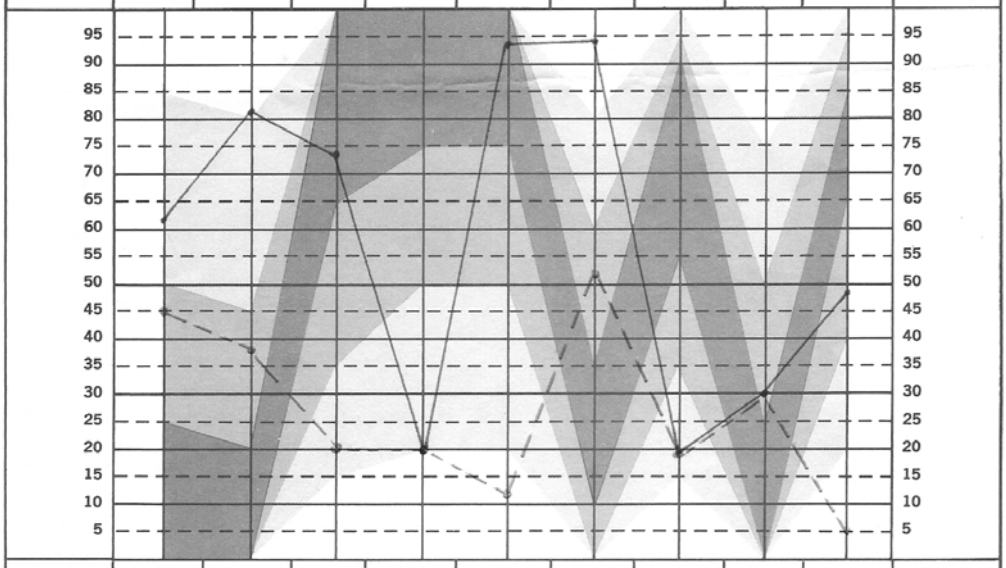
Name [redacted] Age 49 Sex F Date [redacted]

School ____ Grade ____ Degree ____ Major ____ Occupation ____ Counselor EP

Single ____ Years Married ____ Years Divorced ____ Years Widowed ____ Children: M ____ Ages ____ F ____ Ages ____

Answers made by: SELF and/or husband, wife, father, mother, son, daughter, boyfriend, girlfriend or ____ of the person described.

Norm(s):	A	B	C	D	E	F	G	H	I	Attitude (Sten) Score: 4 4
Mids										Total Mids:
Raw score	12 8	16 9	34 22	28 28	38 28	22 8	14 14	2 2	28 12	Raw score
Percentile	62 45	81 38	74 20	20 20	93 11	94 52	20 20	30 30	49 5	Percentile
TRAIT	Nervous	Depressive	Active-Social	Expressive-Responsive	Sympathetic	Subjective	Dominant	Hostile	Self-disciplined	TRAIT



TRAIT OPPOSITE	Composed	Light-hearted	Quiet	Inhibited	Indifferent	Objective	Submissive	Tolerant	Impulsive	TRAIT OPPOSITE

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Objective — Fair-minded, reasonable, logical.
Submissive — Passive, compliant, dependent.
Tolerant — Accepting, patient, humane.
Impulsive — Uncontrolled, disorganized, changeable.

Note: Important decisions should not be made on the basis of this profile without confirmation of these results by other means.

Criss Cross: Husband by wife

Code PR

TAYLOR–JOHNSON TEMPERAMENT ANALYSIS® PROFILE

Profile Revision of 1984

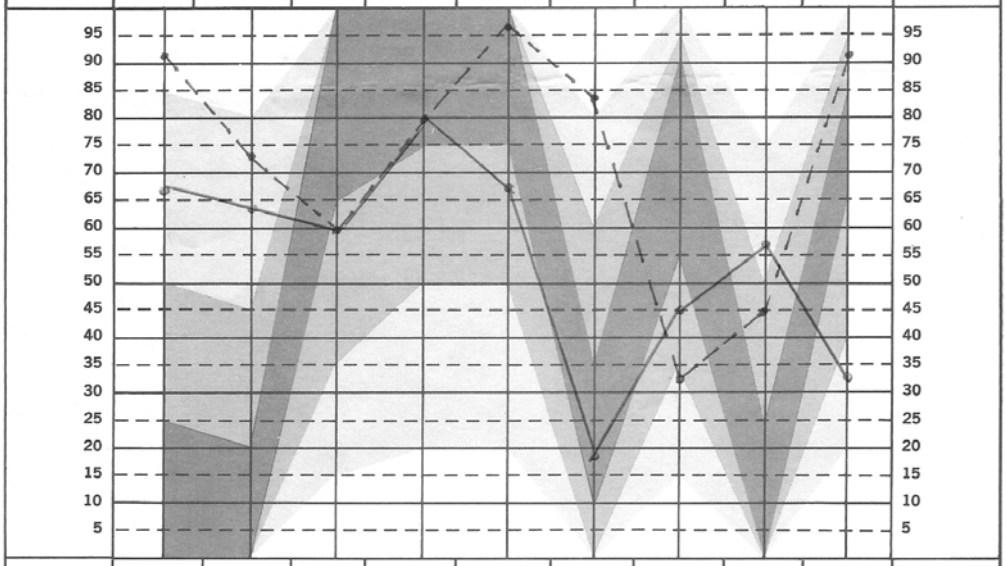
Name [redacted] Age 51 Sex M Date [redacted]

School ____ Grade ____ Degree ____ Major ____ Occupation ____ Counselor EP

Single ____ Years Married ____ Years Divorced ____ Years Widowed ____ Children: M ____ Ages ____ F ____ Ages ____

Answers made by: (SELF) (and/or) husband, (wife) father, mother, son, daughter, boyfriend, girlfriend or ____ of the person described.

Norm(s):	A	B	C	D	E	F	G	H	I	Attitude (Sten) Score: 4 4
Mids										Total Mids: 0
Raw score	20 10	8 6	30 30	36 34	38 34	14 2	22 29	6 8	36 29	Raw score
Percentile	91 46	73 49	60 60	80 80	96 67	84 19	33 45	45 51	91 33	Percentile
TRAIT	Nervous	Depressive	Active-Social	Expressive-Responsive	Sympathetic	Subjective	Dominant	Hostile	Self-disciplined	TRAIT



TRAIT OPPOSITE	Composed	Light-hearted	Quiet	Inhibited	Indifferent	Objective	Submissive	Tolerant	Impulsive	TRAIT OPPOSITE

Excellent | Acceptable | Improvement desirable | Improvement needed

DEFINITIONS

TRAITS

Nervous — Tense, high-strung, apprehensive.
Depressive — Pessimistic, discouraged, dejected.
Active-Social — Energetic, enthusiastic, socially involved.
Expressive-Responsive — Spontaneous, affectionate, demonstrative.
Sympathetic — Kind, understanding, compassionate.
Subjective — Emotional, illogical, self-absorbed.
Dominant — Confident, assertive, competitive.
Hostile — Critical, argumentative, punitive.
Self-disciplined — Controlled, methodical, persevering.

OPPOSITES

Composed — Calm, relaxed, tranquil.
Light-hearted — Happy, cheerful, optimistic.
Quiet — Socially inactive, lethargic, withdrawn.
Inhibited — Restrained, unresponsive, repressed.
Indifferent — Unsympathetic, insensitive, unfeeling.
Objective — Fair-minded, reasonable, logical.
Submissive — Passive, compliant, dependent.
Tolerant — Accepting, patient, humane.
Impulsive — Uncontrolled, disorganized, changeable.

Note: Important decisions should not be made on the basis of this profile without confirmation of these results by other means.

Appendix G

Homework Assignment 1

- **Make a date with your partner before your next session.**

As a couple:

- Tell your partner about something he or she has done for you that you really appreciated.
- Tell your partner about something he or she said to you that you really appreciated.

Have a discussion about:

1. What were your most significant insights from this week's session?
2. What do we need to work on most in improving our communication?
3. What's one concern in our relationship that you would like to discuss with me before this date is over?

Appendix H

Steps to Forgiveness

Scriptures: Matthew 6:24, 18:21-35, Mark 11:25, Ephesians 4:32, Colossians 3:13, 1John 1:9

Definition: Forgiveness is the mental, emotional and/or spiritual process of ceasing to feel resentment or anger against another person for a perceived offence, difference or mistake, or ceasing to demand punishment or restitution.

Note: Two New Testament words we translate "to forgive" mean literally to "let **go**" and/or to "**cancel** a debt."

1. Confront your emotional **pain**.

It is important to note that when we are offended or hurt in someway, God recognizes that we may feel shock, fear, anger, or grief. Apart of forgiveness is acknowledging that an offence has occurred.

We also have to realize that forgiveness can only be appropriate after you have processed out your fear, anger, and grief.

New studies clearly show that anger and resentment doubled the risk of myocardial heart attacks in women with previous coronary problems. Other studies indicate cancer and other deadly illnesses are also caused by anger and resentment. So be willing, for your sake, to begin to process out these deadly emotions as soon as possible.

2. Understand that **love** is what you ultimately want for yourself from yourself. – Jn 13:34

Understand that forgiveness does not condone or approve or forget the harmful acts; forgiveness does not allow yourself to be abused. We forgive the doer, not the doing. Remembering this helps us to break harmful cycles of behavior.

3. Realize that you are **responsible** for your own feelings and for healing the hurt that is going on inside of you.

Be willing to totally face up to that part and accept it without blame (to forgive and love that part).

4. See forgiveness as an **opportunity** for healing and for growth.

Start releasing anger, sadness, grief, and fear through prayer and counseling. Sometimes you may need someone to empathize with you, someone who can be objective and help you shift your perception from blame to healing.
5. **Decide** to forgive.

This decision can be difficult, particularly if you have not processed out the anger, resentment and grief. To forgive you let go of the grudge – of being the "victim", or the "being in the right."

In order to do this, we have to be willing to find a new way to think about the person who wronged us.

6. Forgiveness is a gift you give **yourself.**

It has nothing to do with whether the other person can admit they are wrong. You are forgiving to liberate yourself no matter what the other person decides to do.

Be willing to forgive yourself. Tell yourself if you have to, "I'm sorry that I did..." (Whatever it is that you feel contributed to the problem).

Regardless of what the other person does, work towards seeing them with love and goodness. Know that therefore love and goodness are thus flowing to you for your mental and physical health and well-being.

To conclude our session on forgiveness, the following exercise was used:

- Start your time together by sharing something your partner said and did that you appreciated.
- Discuss what you learned from slides 2 and 3.

Is there an issue between you that needs to be resolved? Is mutual forgiveness needed? If so, now it is time to practice what you've been learning. Refer back to slide 5 on forgiveness.

Appendix I

Couples Relationship Inventory - Discharge

Wife - Discharge

Couples Relationship Inventory

Name: [redacted] *Date:* [redacted]

Rate Your Satisfaction in the following areas from 10% to 100%

Print this document & use the key at the bottom of the page to self-score

1.	Commitment	100 %
2.	Respect for each other	100 %
3.	Intimacy - (sharing, spending time together)	60 %
4.	Fidelity	100 %
5.	Romance	70 %
6.	Fun	70 %
7.	Honesty	80 %
8.	Affection	70 %
9.	Sex	70 %
10.	Money	100 %
11.	Responsibility - (score self and partner and divide by 2)	100 %
12.	Lifestyle Plan	100 %
13.	Fighting Fair - (score self and partner and divide by 2)	100 %
14.	Communication	70 %
15.	Shared Values	100 %
16.	Spirituality	70 %
17.	Parenting	100 %
18.	Anger Management	100 %

Husband- Discharge

Couples Relationship Inventory

Name: [redacted] Date: [redacted]

Rate Your Satisfaction in the following areas from 10% to 100%
Print this document & use the key at the bottom of the page to self-score

1.	Commitment	100 %
2.	Respect for each other	100 %
3.	Intimacy - (sharing, spending time together)	65 %
4.	Fidelity	100 %
5.	Romance	75 %
6.	Fun	65 %
7.	Honesty	100 %
8.	Affection	70 %
9.	Sex	70 %
10.	Money	100 %
11.	Responsibility - (score self and partner and divide by 2)	100 %
12.	Lifestyle Plan	100 %
13.	Fighting Fair - (score self and partner and divide by 2)	100 %
14.	Communication	80 %
15.	Shared Values	95 %
16.	Spirituality	60 %
17.	Parenting	90 %
18.	Anger Management	85 %

Couples Inventory Score Sheet Discharge - Score

Total Scores and Divide by 18

NAME: [redacted] Score: 1560 - wife

NAME: [redacted] Score: 1555 - Husband

RAW Score of	1440 and over	80-100%	GOOD
RAW Score of	1260 to 1439	70-79.9%	MODERATE
RAW Score of	1080 to 1259	60-69.9%	FAIR (could use therapy)
RAW Score of	900 to 1079	50-59.9%	POOR (E-mail)
RAW Score of	0 to 889	0-49.9%	FAILING (E-mail)

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